HEALTH CARE FRAUD AND ABUSE

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

ON

H.R. 1850

TO IMPROVE FEDERAL ENFORCEMENT AGAINST HEALTH CARE FRAUD AND ABUSE
AND

H.R. 2326

TO IMPROVE FEDERAL EFFORTS TO COMBAT FRAUD AND ABUSE AGAINST HEALTH CARE PROGRAMS, AND FOR OTHER PURPOSES

SEPTEMBER 28, 1995

Printed for the use of the Committee on Government Reform and Oversight

U.S. GOVERNMENT PRINTING OFFICE

40-028 CC WASHINGTON : 1997

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-054984-1

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HEALTH CARE FRAUD AND ABUSE

THURSDAY, SEPTEMBER 28, 1995

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 2203, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays, Souder, Schiff, Chrysler, Martini, Fox, Towns, Green, and Fattah.

Ex officio present: Representative Clinger.

Staff present: Lawrence J. Halloran, staff director and counsel; Kate Hickey, and Robert Newman, professional staff members; Thomas M. Costa, clerk; Cheryl Phelps, minority professional staff; and Jean Gosa, minority staff assistant.

Mr. SHAYS. I would like to call this hearing to order. I would like to welcome our witnesses and our guests.

The purpose of today's hearing is to examine legislation to fight fraud and abuse in health care programs: H.R. 2326, the Health Care Fraud and Abuse Prevention Act of 1995, introduced recently by the gentleman from New Mexico, Mr. Schiff, and H.R. 1850, the Health Fraud and Abuse Act of 1995, introduced in June by the gentleman from New York, the ranking member of this subcommittee, Mr. Towns.

This is the fourth hearing of this subcommittee on health care fraud and abuse. What we have learned in past hearings compels our consideration of these bills today. We learned how easy it is for a scam artist to steal enormous amounts of money from public and private health plans.

We heard about the ripoff of Medicaid in New York to the tune of $150 million a year in prescription drug diversion; the two provider firms that submitted false claims to Federal health programs paid fines and settlements of $379 million, in one case, and $111 million in another, and yet continued to bill Medicare and Medicaid; and that the Medicare program often pays more than market prices for medical services and supplies. Nearly $1 billion per year could be saved on oxygen concentrators alone if Medicaid paid the same lower price as paid by the Veterans Affairs Department.

We also heard the numbers. Of the more than $1 trillion spent by our Nation on health care this year, the Department of Justice estimates that up to 10 percent, or $100 billion, is siphoned off by those who prey on the system. That's $274 million lost each day.

Medicare and Medicaid, representing about one-fourth of the Nation's health care bill, could lose up to $26 billion this year, or $71 million a day, from fraud and abuse. Losses of this magnitude pose a major threat to the solvency of these essential programs. Yet, as these programs grow, the losses continue to grow. We're losing the battle.

Individuals and organizations defrauding or abusing the systems continue to operate. The lures are great. Few are caught. Penalties are mild. Justice is slow. Prevention and enforcement resources are inadequate. Communication among those authorities who deter and detect those disobeying the rules is limited, at best.

The bills to be discussed today address these problems. This legislation requires Federal enforcement authorities to coordinate their efforts more effectively, establishes a separate account to pay for enforcement funded by fines and penalties, makes public and private health care fraud a Federal crime, imposes substantial fines and prison sentences for health care fraud, establishes rewards for information leading to the conviction of health care cheats, limits health care providers to one universal billing number, expands the authority to exclude abusive providers, and requires HHS to adopt market-sensitive prompt pricing of equipment and services.

H.R. 2326 is an all-payer anti-fraud and abuse bill, whether the violations are against Medicare and Medicaid programs or against private payers. This legislation is one of the most far-reaching anti-fraud and abuse health care bills ever introduced, offering both public and private payers major new prevention and deterrence tools. The Congressional Budget Office estimates that aggressive anti-fraud provisions such as these could save up to $4.1 billion over 7 years.

In this Congress, we are committed to preserving Medicare and Medicaid through reforms that assure a sustainable growth of these programs. The growth of health care fraud is not sustainable. The reforms in this legislation will ensure that, as Federal health care spending grows, fraud and abuse will not grow with it.

In coming weeks, this subcommittee and other House and Senate committees will finalize legislation to strengthen protections against health care fraud. We look forward to working with Mr. Schiff, who sits on the Judiciary Committee, and our colleagues on the Commerce and Ways and Means Committees to enact the toughest anti-fraud laws ever. And we obviously look forward to working with our colleague, the ranking member, Mr. Towns.

We welcome our witnesses. We look forward to the comments and suggestions of Lovola Burgess, past president of AARP, William Mahon of the National Health Care Anti-Fraud Association, Thomas Schatz of Citizens Against Government Waste, Gerald Stern of the Justice Department, and Dr. Helen Smits of the Health Care Finance Administration.

[The prepared statement of Hon. Christopher Shays, and the texts of H.R. 1850 and H.R. 2326 follow:]

STATEMENT OF REP. CHRISTOPHER SHAYS
CHAIRMAN, SUBCOMMITTEE ON HUMAN RESOURCES
AND INTERGOVERNMENTAL RELATIONS

COMBATTING FRAUD AND ABUSE AGAINST HEALTH CARE PROGRAMS WITH LEGISLATION TO ENHANCE PREVENTION AND ENFORCEMENT TOOLS

September 28, 1995

The purpose of today's hearing is to examine legislation to fight fraud and abuse in health care programs: H.R. 2326, "The Health Care Fraud and Abuse Prevention Act of 1995," introduced recently by the gentleman from New Mexico, Mr. Schiff, and H.R. 1850, "The Health Fraud and Abuse Act of 1995," introduced in June by the gentleman from New York, the Ranking Member of this subcommittee, Mr. Towns.

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We've heard about: the rip-off of Medicaid in New York to the tune of $150 million a year in prescription drug diversion; the two provider firms who submitted false claims to federal health programs, paid fines and settlements of $379 million in one case and $111 million in another, and yet continue to bill Medicare and Medicaid; and the Medicare program often paying more than market prices for medical services and supplies. Nearly $1 billion per year could be saved on oxygen concentrators alone if Medicare paid the same lower price as paid by the Veterans Affairs Department.

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* requires federal enforcement authorities to coordinate their efforts more effectively;
* establishes a separate account to pay for enforcement, funded by fines and penalties;
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* imposes substantial fines and prison sentences for health care fraud;
* establishes a reward program for information leading to the conviction of health care cheats;
* limits health care providers to one universal billing number;
* expands the authority to exclude abusive providers; and,
* requires HHS to adopt market sensitive, prompt pricing of equipment and services.

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In coming weeks, this subcommittee and other House and Senate committees will finalize legislation to strengthen protections against health care fraud. We look forward to working with Mr. Schiff who sits on the Judiciary Committee, and our colleagues on the Commerce and Ways and Means committees, to enact the toughest anti-fraud law ever.

We welcome our witnesses. We look forward to the comments and suggestions of Lovola Burgess, past president of AARP, William Mahon of the National Health Care Anti-Fraud Association, Thomas Schatz of Citizens Against Government Waste, Gerald Stern of the Justice Department, and Dr. Helen Smits of the Health Care Finance Administration.

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I

104TH CONGRESS
1ST SESSION

H. R. 1850

To improve Federal enforcement against health care fraud and abuse.

IN THE HOUSE OF REPRESENTATIVES

JUNE 14, 1995

Mr. TOWNS introduced the following bill; which was referred to the Committee on Government Reform and Oversight

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A BILL

To improve Federal enforcement against health care fraud and abuse.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Health Fraud and Abuse Act of 1995".

SEC. 2. HEALTH CARE FRAUD AND ABUSE.

(a) FEDERAL ENFORCEMENT BY INSPECTORS GENERAL.—

(1) AUDITS, INVESTIGATIONS, INSPECTIONS, AND EVALUATIONS.—The Inspector General of each of the Department of Health and Human Services,

the Department of Defense, the Department of Labor, the Office of Personnel Management, and the Department of Veterans Affairs shall conduct audits, civil and criminal investigations, inspections, and evaluations relating to the prevention, detection, and control of health care fraud and abuse in violation of any Federal law.

(2) POWERS.—For purposes of carrying out duties and responsibilities under paragraph (1), each Inspector General referred to in paragraph (1) may exercise powers that are available to the Inspector General for purposes of audits, investigations, and other activities under the Inspector General Act of 1978 (5 U.S.C. App.).

(3) COORDINATION AND REVIEW OF ACTIVITIES OF OTHER FEDERAL, STATE, AND LOCAL AGENCIES.—

(A) PROGRAM.—The Inspector General shall—

(i) jointly establish, on the effective date specified in subsection (j)(1), a program to prevent, detect, and control health care fraud and abuse in violation of any Federal law, which considers the activities of Federal, State, and local law enforce-

ment agencies, Federal and State agencies responsible for the licensing and certification of health care providers, and State agencies designated under subsection (b)(1)(A); and

(ii) publish a description of the program in the Federal Register, by not later than June 30, 1996.

(B) ANNUAL INVESTIGATIVE PLAN.—Each Inspector General referred to in paragraph (1) shall develop an annual investigative plan for the prevention, detection, and control of health care fraud and abuse in accordance with the program established under subparagraph (A).

(4) CONSULTATIONS.—Each of the Inspectors General referred to in paragraph (1) shall regularly consult with each other, with Federal, State, and local law enforcement agencies, with Federal and State agencies responsible for the licensing and certification of health care providers, and with Health Care Fraud and Abuse Control Units, in order to assist in coordinating the prevention, detection, and control of health care fraud and abuse in violation of any Federal law.

(b) STATE ENFORCEMENT.—

(1) DESIGNATION OF STATE AGENCIES AND ESTABLISHMENT OF HEALTH CARE FRAUD AND ABUSE CONTROL UNIT.—The Governor of each State—

(A) shall, consistent with State law, designate agencies of the State which conduct, supervise, and coordinate audits, civil and criminal investigations, inspections, and evaluations relating to the prevention, detection, and control of health care fraud and abuse in violation of any Federal law in the State; and

(B) may establish and maintain in accordance with paragraph (2) a State agency to act as a Health Care Fraud and Abuse Control Unit for purposes of this section.

(2) HEALTH CARE FRAUD AND ABUSE CONTROL UNIT REQUIREMENTS.—A Health Care Fraud and Abuse Control Unit established by a State under paragraph (1)(B) shall be a single identifiable entity of State government which is separate and distinct from any State agency with principal responsibility for the administration of health care programs, and which meets the following requirements:

(A) The entity—

(i) is a unit of the office of the State Attorney General or of another department

of State government that possesses statewide authority to prosecute individuals for criminal violations;

(ii) is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority, and has formal procedures, approved by the Secretary, that assure it will refer suspected criminal violations relating to health care fraud or abuse in violation of any Federal law to the appropriate authority or authorities of the State for prosecution and assure it will assist such authority or authorities in such prosecutions; or

(iii) has a formal working relationship with the office of the State Attorney General or the appropriate authority or authorities for prosecution and has formal procedures (including procedures under which it will refer suspected criminal violations to such office), that provide effective coordination of activities between the Health Care Fraud and Abuse Control Unit and such office with respect to the

detection, investigation, and prosecution of suspected health care fraud or abuse in violation of any Federal law.

(B) The entity conducts a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of health care fraud and abuse in violation of any Federal law.

(C) The entity has procedures for—

(i) reviewing complaints of the abuse or neglect of patients of health care facilities in the State; and

(ii) where appropriate, investigating and prosecuting such complaints under the criminal laws of the State or for referring the complaints to other State or Federal agencies for action.

(D) The entity provides for the collection, or referral for collection to the appropriate agency, of overpayments that—

(i) are made under any federally funded or mandated health care program required by this Act; and

(ii) it discovers in carrying out its activities.

(E) The entity employs attorneys, auditors, investigators, and other necessary personnel, is organized in such a manner, and provides sufficient resources, as is necessary to promote the effective and efficient conduct of its activities.

(3) SUBMISSION OF ANNUAL PLAN.—Each Health Care Fraud and Abuse Control Unit may submit each year to the Inspector General a plan for preventing, detecting, and controlling, consistent with the program established under subsection (a)(3)(A), health care fraud and abuse in violation of any Federal law.

(4) APPROVAL OF ANNUAL PLAN.—The Inspector General shall approve a plan submitted under paragraph (3) by the Health Care Fraud and Abuse Control Unit of a State, unless the Inspector General establishes that the plan—

(A) is inconsistent with the program established under subsection (a)(3)(A); or

(B) will not enable the agencies of the State designated under paragraph (1)(A) to prevent, detect, and control health care fraud and abuse in violation of any Federal law.

(5) REPORTS.—Each Health Care Fraud and Abuse Control Unit shall submit to the Inspector

General an annual report containing such information as the Inspector General determines to be necessary.

(6) SEMIANNUAL REPORTS OF INSPECTOR GENERAL OF HEALTH AND HUMAN SERVICES.—The Inspector General shall include in each semiannual report of the Inspector General to the Congress under section 5(a) of the Inspector General Act of 1978 (5 U.S.C. App.) an assessment of the Inspector General of how well States are preventing, detecting, and controlling health care fraud and abuse.

(c) PAYMENTS TO STATES.—

(1) IN GENERAL.—For each year for which a State has a plan approved under subsection (b)(4), and subject to the availability of appropriations, the Inspector General shall pay to the State for each quarter an amount equal to 75 percent of the sums expended during the quarter by agencies designated by the Governor of the State under subsection (b)(1)(A) in conducting activities described in that subsection.

(2) TIME OF PAYMENT.—The Inspector General shall make a payment under paragraph (1) for a quarter by not later than 30 days after the end of the quarter.

(3) PAYMENTS ARE ADDITIONAL.—Payments to a State under this subsection shall be in addition to any amounts paid under subsection (g).

(d) DATA SHARING.—The Inspector General shall establish a program for the sharing among Federal agencies, State and local law enforcement agencies, and health care providers and insurers, consistent with data sharing provisions of subtitle B, of data related to possible health care fraud and abuse in violation of any Federal law.

(e) HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—

(1) ESTABLISHMENT.—There is established on the books of the Treasury of the United States a separate account, which shall be known as the Health Care Fraud and Abuse Control Account. The Account shall consist of—

(A) the Health Care Fraud and Abuse Expenses Subaccount; and

(B) the Health Care Fraud and Abuse Reserve Subaccount.

(2) EXPENSES SUBACCOUNT.—

(A) CONTENTS.—The Expenses Subaccount consists of—

(i) amounts deposited under subparagraph (B); and

(ii) amounts transferred from the Reserve Subaccount and deposited under paragraph (3)(B).

(B) DEPOSITS.—Except as provided in paragraph (3)(A), there shall be deposited in the Expenses Subaccount all amounts received by the United States as—

(i) fines for health care fraud and abuse in violation of any Federal law;

(ii) civil penalties or damages (other than restitution) in actions under section 3729 or 3730 of title 31, United States Code (commonly referred to as the "False Claims Act"), that are based on health care fraud and abuse in violation of any Federal law;

(iii) administrative penalties under the Social Security Act;

(iv) proceeds of seizures and forfeitures of property for acts or omissions that constitute health care fraud or abuse in violation of any Federal law; and

(v) money and proceeds of property that are accepted under subsection (f).

(C) USE.—Amounts in the Expenses Subaccount shall be available to the Inspector General, under such terms and conditions as the Inspector General determines to be appropriate, for—

(i) paying expenses incurred by their respective agencies in carrying out activities under subsection (a); and

(ii) making reimbursements to other Inspectors General and Federal, State, and local agencies in accordance with subsection (g).

(3) RESERVE SUBACCOUNT.—

(A) DEPOSITS.—An amount otherwise required under paragraph (2)(A) to be deposited in the Expenses Subaccount in a fiscal year shall be deposited in the Reserve Subaccount, if—

(i) the amount in the Expenses Subaccount is greater than $500,000,000; and

(ii) the deposit of that amount in the Expenses Subaccount would result in the amount in the Expenses Subaccount exceeding 110 percent of the total amount

deposited in the Expenses Subaccount in the preceding fiscal year.

(B) TRANSFERS TO EXPENSES SUBACCOUNT.—

(i) ESTIMATION OF SHORTFALL.—Not later than the first day of the last quarter of each fiscal year, the Inspector General shall estimate whether sufficient amounts will be available during such quarter in the Expenses Subaccount for the uses described in paragraph (2)(C).

(ii) TRANSFER TO COVER SHORTFALL.—If the Inspector General estimates under clause (i) that there will not be available sufficient amounts in the Expenses Subaccount during the last quarter of a fiscal year, there shall be transferred from the Reserve Subaccount and deposited in the Expenses Subaccount such amount as the Inspector General estimates is required to ensure that sufficient amounts are available in the Expenses Subaccount during such quarter.

(C) LIMITATION ON AMOUNT CARRIED OVER TO SUCCEEDING FISCAL YEAR.—There

shall be transferred to the general fund of the Treasury any amount remaining in the Reserve Subaccount at the end of a fiscal year (after any transfer made under subparagraph (B)) in excess of 10 percent of the total amount authorized to be deposited in the Expenses Subaccount (consistent with subparagraph (A)) during the fiscal year.

(f) ACCEPTANCE OF GIFTS, BEQUESTS, AND DEVISES.—Any Inspector General referred to in subsection (a)(1) may accept, use, and dispose of gifts, bequests, or devises of services or property (real or personal), for the purpose of aiding or facilitating activities under this section regarding health care fraud and abuse. Gifts, bequests, or devises of money and proceeds from sales of other property received as gifts, bequests, or devises shall be deposited in the Account and shall be available for use in accordance with subsection (e)(2)(C).

(g) REIMBURSEMENTS OF EXPENSES AND OTHER PAYMENTS TO PARTICIPATING AGENCIES.—

(1) REIMBURSEMENT OF EXPENSES OF FEDERAL AGENCIES.—The Inspector General, subject to the availability of amounts in the Account, shall promptly reimburse Federal agencies for expenses incurred in carrying out subsection (a).

(2) PAYMENTS TO STATE AND LOCAL LAW ENFORCEMENT AGENCIES.—The Inspector General, subject to the availability of amounts in the Account, shall promptly pay to any State or local law enforcement agency that participated directly in any activity which led to deposits in the Account, or property the proceeds of which are deposited in the Account, an amount that reflects generally and equitably the participation of the agency in the activity.

(3) FUNDS USED TO SUPPLEMENT AGENCY APPROPRIATIONS.—It is intended that disbursements made from the Account to any Federal agency be used to increase and not supplant the recipient agency's appropriated operating budget.

(h) ACCOUNT PAYMENTS ADVISORY BOARD.—

(1) ESTABLISHMENT.—There is established the Account Payments Advisory Board, which shall make recommendations to the Inspector General regarding the equitable allocation of payments from the Account.

(2) MEMBERSHIP.—The Board shall consist of—

(A) each of the Inspectors General referred to in subsection (a)(1), other than the Inspector

General of the Department of Health and Human Services; and

(B) 10 members appointed by the Inspector General of the Department of Health and Human Services to represent Health Care Fraud and Abuse Control Units, of whom one shall be appointed—

(i) for each of the 10 regions established by the Director of the Office of Management and Budget under Office of Management and Budget Circular A–105, to represent Units in that region; and

(ii) from among individuals recommended by the heads of those agencies in that region.

(3) TERMS.—The term of a member of the Board appointed under paragraph (2)(B) shall be 3 years, except that of such members first appointed 3 members shall serve an initial term of one year and 3 members shall serve an initial term of 2 years, as specified by the Inspector General at the time of appointment.

(4) VACANCIES.—A vacancy on the Board shall be filled in the same manner in which the original appointment was made, except that an individual ap-

pointed to fill a vacancy occurring before the expiration of the term for which the individual is appointed shall be appointed only for the remainder of that term.

(5) CHAIRPERSON AND BYLAWS.—The Board shall elect one of its members as chairperson and shall adopt bylaws.

(6) COMPENSATION AND EXPENSES.—Members of the Board shall serve without compensation, except that the Inspector General may pay the expenses reasonably incurred by the Board in carrying out its functions under this section.

(7) NO TERMINATION.—Section 14(a)(2) of the Federal Advisory Committee Act (5 U.S.C. App.) does not apply to the Board.

(i) DEFINITIONS.—In this section:

(1) ACCOUNT.—The term "Account" means the Health Care Fraud and Abuse Control Account established by subsection (e)(1).

(2) EXPENSES SUBACCOUNT.—The term "Expenses Subaccount" means the Health Care Fraud and Abuse Expenses Subaccount of the Account.

(3) HEALTH CARE FRAUD AND ABUSE CONTROL UNIT.—The term "Health Care Fraud and Abuse

Control Unit'' means such a unit established by a State in accordance with subsection (b)(2).

(4) INSPECTOR GENERAL.—Except as otherwise provided, the term ''Inspector General'' means the Inspector General of the Department of Health and Human Services.

(5) RESERVE SUBACCOUNT.—The term ''Reserve Subaccount'' means the Health Care Fraud and Abuse Reserve Subaccount of the Account.

(j) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), this section shall take effect on January 1, 1997.

(2) DEVELOPMENT AND PUBLICATION OF DESCRIPTION OF PROGRAM.—Subsection (a)(3)(A) shall take effect on the date of the enactment of this Act.

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I

104TH CONGRESS
1ST SESSION

H. R. 2326

To improve Federal efforts to combat fraud and abuse against health care programs, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 13, 1995

Mr. SCHIFF (for himself, Mr. SHAYS, Mr. CLINGER, Mr. FOX of Pennsylvania, Mr. SCHUMER, and Mr. TOWNS) introduced the following bill; which was referred to the Committee on the Judiciary, and in addition to the Committees on Government Reform and Oversight, Ways and Means, and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To improve Federal efforts to combat fraud and abuse against health care programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Health Care Fraud and Abuse Prevention Act of 1995".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—COORDINATION OF FEDERAL ENFORCEMENT

TITLE II—REVISIONS TO CRIMINAL LAW

TITLE III—ANTI-FRAUD INITIATIVES UNDER MEDICARE AND MEDICAID

TITLE I—COORDINATION OF FEDERAL ENFORCEMENT

SEC. 101. FEDERAL ENFORCEMENT BY INSPECTORS GENERAL AND ATTORNEY GENERAL.

(a) AUDITS, INVESTIGATIONS, INSPECTIONS, AND EVALUATIONS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Inspector General of each of the Department of Health and Human Services, the Department of Defense, the Department of Labor, the Office of Personnel Management, and the Department of Veterans Affairs, and the Attorney General shall conduct audits, civil and criminal investigations, inspections, and evaluations relating to the prevention, detection, and control of health care fraud and abuse in violation of any Federal law.

(2) LIMITATION.—An Inspector General, other than the Inspector General of the Department of Health and Human Services, may not conduct any audit, investigation, inspection, or evaluation under paragraph (1) with respect to health care fraud or abuse under title V, XI, XVIII, XIX, or XX of the Social Security Act.

(b) POWERS.—For purposes of carrying out duties and responsibilities under subsection (a), each Inspector

General referred to in subsection (a) may exercise powers that are available to the Inspector General for purposes of audits, investigations, and other activities under the Inspector General Act of 1978 (5 U.S.C. App.).

(c) COORDINATION AND REVIEW OF ACTIVITIES OF OTHER FEDERAL, STATE, AND LOCAL AGENCIES.—

(1) PROGRAM.—The Inspector General and the Attorney General shall—

(A) jointly establish, on the effective date specified in section 110(a), a program to prevent, detect, and control health care fraud and abuse in violation of any Federal law, which takes into account the activities of Federal, State, and local law enforcement agencies, Federal and State agencies responsible for the licensing and certification of health care providers, and State agencies designated under section 102(a)(1); and

(B) publish a description of the program in the Federal Register, by not later than 180 days after the date of the enactment of this Act.

(2) ANNUAL INVESTIGATIVE PLAN.—Each Inspector General referred to in subsection (a)(1) and the Attorney General shall each develop an annual

investigative plan for the prevention, detection, and control of health care fraud and abuse in accordance with the program established under paragraph (1).

(d) CONSULTATIONS.—Each of the Inspectors General referred to in subsection (a)(1) and the Attorney General shall regularly consult with each other, with Federal, State, and local law enforcement agencies, with Federal and State agencies responsible for the licensing and certification of health care providers, and with Health Care Fraud and Abuse Control Units, in order to assist in coordinating the prevention, detection, and control of health care fraud and abuse in violation of any federal law.

SEC. 102. STATE ENFORCEMENT.

(a) DESIGNATION OF STATE AGENCIES AND ESTABLISHMENT OF HEALTH CARE FRAUD AND ABUSE CONTROL UNIT.—The Governor of each State—

(1) shall, consistent with State law, designate agencies of the State which conduct, supervise, and coordinate audits, civil and criminal investigations, inspections, and evaluations relating to the prevention, detection, and control of health care fraud and abuse in violation of any Federal law in the State; and

(2) may establish and maintain in accordance with subsection (b) a State agency to act as a

Health Care Fraud and Abuse Control Unit for purposes of this title.

(b) HEALTH CARE FRAUD AND ABUSE CONTROL UNIT REQUIREMENTS.—A Health Care Fraud and Abuse Control Unit established by a State under subsection (a)(2) shall be a single identifiable entity of State government which is separate and distinct from any State agency with principal responsibility for the administration of health care programs, and which meets the following requirements:

(1) The entity—

(A) is a unit of the office of the State Attorney General or of another department of State government that possesses statewide authority to prosecute individuals for criminal violations;

(B) is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority, and has formal procedures, approved by the Secretary, that assure it will refer suspected criminal violations relating to health care fraud or abuse in violation of any Federal law to the appropriate authority or authorities of the State for pros-

ecution and assure it will assist such authority or authorities in such prosecutions; or

(C) has a formal working relationship with the office of the State Attorney General or the appropriate authority or authorities for prosecution and has formal procedures (including procedures under which it will refer suspected criminal violations to such office), that provide effective coordination of activities between the Health Care Fraud and Abuse Control Unit and such office with respect to the detection, investigation, and prosecution of suspected health care fraud or abuse in violation of any Federal law.

(2) The entity conducts a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of health care fraud and abuse under Federal law.

(3) The entity has procedures for—

(A) reviewing complaints of the abuse or neglect of patients of health care facilities in the State, and

(B) where appropriate, investigating and prosecuting such complaints under the criminal

laws of the State or for referring the complaints to other State or Federal agencies for action.

(4) The entity provides for the collection, or referral for collection to the appropriate agency, of overpayments that—

(A) are made under any federally funded or mandated health care program required by this Act, and

(B) it discovers in carrying out its activities.

(5) The entity employs attorneys, auditors, investigators, and other necessary personnel, is organized in such a manner, and provides sufficient resources, as is necessary to promote the effective and efficient conduct of its activities.

(c) SUBMISSION OF ANNUAL PLAN.—Each Health Care Fraud and Abuse Control Unit may submit each year to the Inspector General and the Attorney General a plan for preventing, detecting, and controlling, consistent with the program established under section 101(c)(1), health care fraud and abuse in violation of any Federal law.

(d) APPROVAL OF ANNUAL PLAN.—The Inspector General shall approve a plan submitted under subsection (c) by the Health Care Fraud and Abuse Control Unit

of a State, unless the Inspector General establishes that the plan—

(1) is inconsistent with the program established under section 101(c)(1); or

(2) will not enable the agencies of the State designated under subsection (a)(1) to prevent, detect, and control health care fraud and abuse in violation of any Federal law.

(e) REPORTS.—Each Health Care Fraud and Abuse Control Unit shall submit to the Inspector General an annual report containing such information as the Inspector General determines to be necessary.

(f) SEMIANNUAL REPORTS OF INSPECTOR GENERAL OF HEALTH AND HUMAN SERVICES.—The Inspector General shall include in its semiannual reports to the Congress under section 5(a) of the Inspector General Act of 1978 (5 U.S.C. App.) an assessment of the Inspector General of the effectiveness of States in preventing, detecting, and controlling health care fraud and abuse.

SEC. 103. PAYMENTS TO STATES.

(a) IN GENERAL.—For each year for which a State has an annual plan approved under section 102(d), and subject to the availability of appropriations, the Inspector General shall pay to the State for each quarter an amount equal to 75 percent of the sums expended during the quar-

ter by agencies designated by the Governor of the State under section 102(a)(1) in conducting activities described in that subsection.

(b) TIME OF PAYMENT.—The Inspector General shall make a payment under subsection (a) for a quarter by not later than 30 days after the end of the quarter.

(c) PAYMENTS ARE ADDITIONAL.—Payments to a State under this subsection shall be in addition to any amounts paid under section 106.

SEC. 104. HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.

(a) ESTABLISHMENT.—There is established on the books of the Treasury of the United States a separate account, which shall be known as the Health Care Fraud and Abuse Control Account. The Account shall consist of—

(1) the Health Care Fraud and Abuse Expenses Subaccount; and

(2) the Health Care Fraud and Abuse Reserve Subaccount.

(b) EXPENSES SUBACCOUNT.—

(1) CONTENTS.—The Expenses Subaccount consists of—

(A) amounts deposited under paragraph (2); and

(B) amounts transferred from the Reserve Subaccount under subsection (c)(2).

(2) DEPOSITS.—Except as provided in subsection (c)(1), there shall be deposited in the Expenses Subaccount all amounts received by the United States as—

(A) fines imposed in cases involving a Federal health care offense;

(B) civil penalties or damages (other than restitution) in actions under section 3729 or 3730 of title 31, United States Code (commonly referred to as the "False Claims Act"), that are based on claims related to the provision of health care items and services;

(C) administrative penalties under titles XI, XVIII, and XIX of the Social Security Act;

(D) proceeds of seizures and forfeitures of property for acts or omissions in violation of any Federal law related to the provision of health care items and services; and

(E) money and proceeds of property that are accepted under section 105.

(3) USE.—Amounts in the Expenses Subaccount shall be available to the Inspector General and the Attorney General, under such terms and

conditions as the Inspector General and the Attorney General jointly determine to be appropriate, for—

(A) paying expenses incurred by their respective agencies in carrying out activities under section 101; and

(B) making reimbursements to other Inspectors General and Federal, State, and local agencies in accordance with section 106.

(c) RESERVE SUBACCOUNT.—

(1) DEPOSITS.—An amount otherwise required under subsection (b)(1) to be deposited in the Expenses Subaccount in a fiscal year shall be deposited in the Reserve Subaccount, if—

(A) the amount in the Expenses Subaccount is greater than $500,000,000; and

(B) the deposit of that amount in the Expenses Subaccount would result in the amount in the Expenses Subaccount exceeding 110 percent of the total amount deposited in the Expenses Subaccount in the preceding fiscal year.

(2) TRANSFERS TO EXPENSES SUBACCOUNT.—

(A) ESTIMATION OF SHORTFALL.—Not later than the first day of the last quarter of each fiscal year, the Inspector General (in con-

sultation with the Attorney General) shall estimate whether sufficient amounts will be available during such quarter in the Expenses Subaccount for the uses described in subsection (b)(3).

(B) TRANSFER TO COVER SHORTFALL.—If the Inspector General estimates under subsection (a) that there will not be available sufficient amounts in the Expenses Subaccount during the last quarter of a fiscal year, there shall be transferred from the Reserve Subaccount to the Expenses Subaccount such amount as the Inspector General estimates is required to ensure that sufficient amounts are available in the Expenses Subaccount during such quarter.

(3) LIMITATION ON AMOUNT CARRIED OVER TO SUCCEEDING FISCAL YEAR.—There shall be transferred to the general fund of the Treasury any amount remaining in the Reserve Subaccount at the end of a fiscal year (after any transfer made under paragraph (2)) in excess of 10 percent of the total amount authorized to be deposited in the Expenses Subaccount (consistent with paragraph (1)) during the fiscal year.

(d) RESTRICTION ON DEPOSITS.—In the case of a Federal health care offense, the attorney for the Government may not, in exchange for payment by a defendant of a fine or other monetary amount to be deposited in the Account, reduce the exposure of the defendant to a term of imprisonment by moving for dismissal or reduction of charges, agreeing to dismiss charges, agreeing not to bring charges, or recommending a lesser sentence.

(e) ANNUAL REPORT TO CONGRESS.—Not later than 180 days after the end of each fiscal year (beginning with fiscal year 1996), the Secretary of Health and Human Services and the Attorney General shall submit a report to the Committee on Government Reform and Oversight of the House of Representatives and the Committee on Governmental Affairs of the Senate on the operations of the Account during the fiscal year, including a description of the deposits made into the Account and the payments made from the Account during the year.

SEC. 105. ACCEPTANCE OF GIFTS, BEQUESTS, AND DEVISES.

The Attorney General or any Inspector General referred to in section 101(a) may accept, use, and dispose of gifts, bequests, or devises of services or property (real or personal), for the purpose of aiding or facilitating activities under this title regarding health care fraud and abuse. Gifts, bequests, or devises of money and proceeds

from sales of other property received as gifts, bequests, or devises shall be deposited in the Account and shall be available for use in accordance with section 104(b)(3).

SEC. 106. REIMBURSEMENTS OF EXPENSES AND OTHER PAYMENTS TO PARTICIPATING AGENCIES.

(a) REIMBURSEMENT OF EXPENSES OF FEDERAL AGENCIES.—The Inspector General and the Attorney General, subject to the availability of amounts in the Account, shall jointly and promptly reimburse Federal agencies for expenses incurred in carrying out section 101.

(b) PAYMENTS TO STATE AND LOCAL LAW ENFORCEMENT AGENCIES.—The Inspector General and the Attorney General, subject to the availability of amounts in the Account, shall jointly and promptly pay to any State or local law enforcement agency that participated directly in any activity which led to deposits in the Account, or property the proceeds of which are deposited in the Account, an amount that reflects generally and equitably the participation of the agency in the activity.

(c) FUNDS USED TO SUPPLEMENT AGENCY APPROPRIATIONS.—It is intended that disbursements made from the Account to any Federal agency be used to increase and not supplant the recipient agency's appropriated operating budget.

SEC. 107. ACCOUNT PAYMENTS ADVISORY BOARD.

(a) ESTABLISHMENT.—There is established the Account Payments Advisory Board, which shall make recommendations to the Inspector General and the Attorney General regarding the equitable allocation of payments from the Account.

(b) MEMBERSHIP.—The Board shall consist of—

(1) each of the Inspectors General referred to in section 101(a), other than the Inspector General of the Department of Health and Human Services; and

(2) 10 members appointed by the Inspector General of the Department of Health and Human Services to represent Health Care Fraud and Abuse Control Units, of whom one shall be appointed—

(A) for each of the 10 regions established by the Director of the Office of Management and Budget under Office of Management and Budget Circular A–105, to represent Units in that region; and

(B) from among individuals recommended by the heads of those agencies in that region.

(c) TERMS.—The term of a Member of the Board appointed under subsection (b)(2) shall be 3 years, except that of such members first appointed 3 members shall serve an initial term of one year and 3 members shall serve

an initial term of 2 years, as specified by the Inspector General at the time of appointment.

(d) VACANCIES.—A vacancy on the Board shall be filled in the same manner in which the original appointment was made, except that an individual appointed to fill a vacancy occurring before the expiration of the term for which the individual is appointed shall be appointed only for the remainder of that term.

(e) CHAIRPERSON AND BYLAWS.—The Board shall elect one of its members as chairperson and shall adopt bylaws.

(f) COMPENSATION AND EXPENSES.—Members of the Board shall serve without compensation, except that the Inspector General may pay the expenses reasonably incurred by the Board in carrying out its functions under this section.

(g) NO TERMINATION.—Section 14(a)(2) of the Federal Advisory Committee Act (5 U.S.C. App.) does not apply to the Board.

SEC. 108. ESTABLISHMENT OF HEALTH CARE FRAUD AND ABUSE DATA BASE.

(a) IN GENERAL.—The Secretary of Health and Human Services, in consultation with the Attorney General, shall establish a data base for the reporting of final adverse actions taken by a Government agency against

health care providers, suppliers, or practitioners, or against health care benefit programs, in order to provide a central repository of such information to assist in the prevention, detection, and prosecution of health care fraud and abuse.

(b) REPORTING INFORMATION.—

(1) IN GENERAL.—For purposes of establishing and maintaining the data base under this section, each Government agency shall report any final adverse action taken against a health care provider, supplier, or practitioner, or against a health care benefit program, together with the information described in paragraph (2).

(2) INFORMATION TO BE REPORTED.—The information referred to in this paragraph is as follows:

(A) The name of any health care insurer, provider, supplier, or practitioner or health care benefit program which is the subject of the final adverse action reported under paragraph (1).

(B) In the case of a final adverse action taken against a health care provider, supplier, or practitioner, the name (if known) of any health care benefit program with which the insurer, provider, supplier, or practitioner is affiliated or associated.

(C) The nature of the final adverse action.

(D) A description of the acts or omissions and injuries upon which the final adverse action was based.

(E) Such other information as required by the Secretary.

(3) CONFIDENTIALITY.—The Secretary shall establish procedures to assure that in the submission of information under this subsection the privacy of individuals receiving health care services is appropriately protected.

(4) FORM AND MANNER OF REPORTING.—The information required to be reported under this subsection shall be reported on a monthly basis and in such form and manner as determined by the Secretary. Such information shall first be required to be reported on a date specified by the Secretary.

(5) TO WHOM REPORTED.—The information required to be reported under this subsection shall be reported to the Secretary or such person or persons designated by the Secretary.

(c) CORRECTION OF ERRONEOUS INFORMATION.—

(1) DISCLOSURE AND CORRECTION.—The Secretary shall provide for a procedure through which a person, to whom information within the data base

established under this section pertains, may review that information and obtain the correction of errors pertaining to that person.

(2) OTHER CORRECTIONS.—Each Government agency shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, or a health care benefit program, in such form and manner as required by the Secretary.

(d) ACCESS TO REPORTED INFORMATION.—

(1) AVAILABILITY.—The information in this data base shall be available to the public, Federal and State law enforcement agencies, Federal and State government agencies, and health care benefit programs pursuant to procedures established by the Secretary and Attorney General.

(2) FEES.—The Secretary may establish reasonable fees for the disclosure of information in this data base.

(e) PROTECTION FROM LIABILITY FOR REPORTING.—No person may be held liable in any civil action with respect to reporting information required to be reported under this section, unless the information reported was false and the person had knowledge of the falsity of the information.

(f) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

(1) The term "final adverse action" includes the following:

(A) Civil judgments in Federal or State court related to the delivery of a health care item or service.

(B) Federal or State criminal convictions related to the delivery of a health care item or service, as determined in accordance with procedures applicable to the exclusion of individuals and entities under section 1128(j) of the Social Security Act.

(C) Actions by State or Federal agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—

(i) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation;

(ii) any other loss of license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender or otherwise; or

(iii) any other negative action or finding by such State or Federal agency that is publicly available information.

(D) Exclusion from participation in Federal or State health care programs.

(E) Any other actions as required by the Secretary.

(2) The term "Government agency" includes—

(A) the Department of Justice;

(B) the Department of Health and Human Services;

(C) any other Federal agency that either administers or provides payment for the delivery of health care services, including (but not limited to) the Department of Defense and the Department of Veterans Affairs;

(D) State law enforcement agencies;

(E) State Medicaid fraud and abuse control units described in section 1903(q) of the Social Security Act; and

(F) State or Federal agencies responsible for the licensing and certification of health care providers and licensed health care practitioners.

(3) The term "health care benefit program" has the meaning given such term in section 1347(b) of

title 18, United States Code, as added by section 202(b).

(4) The term "health care provider" means a provider of services (as defined in section 1861(u) of the Social Security Act) and any entity, including a health maintenance organization or group medical practice, that provides health care services (as specified by the Secretary in regulations).

(5) The terms "licensed health care practitioner" and "practitioner" mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services (or any individual who without authority holds himself or herself out to be so licensed or authorized).

(6) The term "Secretary" means the Secretary of Health and Human Services.

(7) The term "supplier" means a supplier of items and services for which payment may be made under part B of title XVIII of the Social Security Act.

SEC. 109. DEFINITIONS.

In this title:

(1) ACCOUNT.—The term "Account" means the Health Care Fraud and Abuse Control Account established by section 104(a).

(2) EXPENSES SUBACCOUNT.—The term "Expenses Subaccount" means the Health Care Fraud and Abuse Expenses Subaccount of the Account.

(3) FEDERAL HEALTH CARE OFFENSE.—The term "Federal health care offense" has the meaning given such term in section 24(a) of title 18, United States Code.

(4) HEALTH CARE FRAUD AND ABUSE CONTROL UNIT.—The term "Health Care Fraud and Abuse Control Unit" means such a unit established by a State in accordance with section 102(b).

(5) INSPECTOR GENERAL.—Except as otherwise provided, the term "Inspector General" means the Inspector General of the Department of Health and Human Services.

(6) RESERVE SUBACCOUNT.—The term "Reserve Subaccount" means the Health Care Fraud and Abuse Reserve Subaccount of the Account.

SEC. 110. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in subsection (b), this title shall take effect after the expiration of the 180-day period which begins on the date of the enactment of this Act.

(b) DEVELOPMENT AND PUBLICATION OF DESCRIPTION OF PROGRAM.—Section 101(c)(1) shall take effect on the date of the enactment of this Act.

TITLE II—REVISIONS TO CRIMINAL LAW

SEC. 201. DEFINITION OF FEDERAL HEALTH CARE OFFENSE.

(a) IN GENERAL.—Chapter 2 of title 18, United States Code, is amended by adding at the end the following:

"§ 24. Definition of Federal health care offense

"(a) As used in this title, the term 'Federal health care offense' means—

"(1) a violation of, or criminal conspiracy to violate section 226, 227, 669, 1035, 1347, or 1518 of this title;

"(2) a violation of, or criminal conspiracy to violate section 1128B of the Social Security Act (42 U.S.C. 1320a–7b);

"(3) a violation of, or criminal conspiracy to violate section 201, 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of this title, if the violation or conspiracy relates to a health care benefit program;

"(4) a violation of, or criminal conspiracy to violate section 501 or 511 of the Employee Retire-

ment Income Security Act of 1974 (29 U.S.C. 1131 or 29 U.S.C. 1141), if the violation or conspiracy relates to a health care benefit program;

"(5) the commission of, or attempt to commit, an act which constitutes grounds for the imposition of a penalty under section 303 of the Federal Food, Drug, and Cosmetic Act, if the act or attempt relates to a health care benefit program; or

"(6) a violation of, or criminal conspiracy to violate, section 3 of the Anti-Kickback Act of 1986 (41 U.S.C. 53), if the violation or conspiracy relates to a health care benefit program.

"(b) As used in this title, the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 2 of title 18, United States Code, is amended by inserting after the item relating to section 23 the following new item:

"24. Definition relating to Federal health care offense defined.".

SEC. 202. HEALTH CARE FRAUD.

(a) IN GENERAL.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"§ 1347. Health care fraud

"(a) Whoever, having devised or intending to devise a scheme or artifice, commits or attempts to commit an act in furtherance of or for the purpose of executing such scheme or artifice—

"(1) to defraud any health care benefit program; or

"(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program,

shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title), such person shall be fined under this title or imprisoned not more than 20 years, or both; and if the violation results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.

"(b) As used in this section, the term 'health care benefit program' means any public or private plan or contract under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"1347. Health care fraud.".

SEC. 203. THEFT OR EMBEZZLEMENT.

(a) IN GENERAL.—Chapter 31 of title 18, United States Code, is amended by adding at the end the following:

"§ 669. Theft or embezzlement in connection with health care

"(a) Whoever embezzles, steals, or otherwise without authority willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program, shall be fined under this title or imprisoned not more than 10 years, or both.

"(b) As used in this section, the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 31 of title 18, United States Code, is amended by adding at the end the following:

"669. Theft or embezzlement in connection with health care.".

SEC. 204. FALSE STATEMENTS.

(a) IN GENERAL.—Chapter 47 of title 18, United States Code, is amended by adding at the end the following:

"§ 1035. False statements relating to health care matters

"(a) Whoever, in any matter involving a health care benefit program, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry, shall be fined under this title or imprisoned not more than 5 years, or both.

"(b) As used in this section, the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 18, United States Code, is amended by adding at the end the following new item:

"1035. False statements relating to health care matters.".

SEC. 205. BRIBERY AND GRAFT.

(a) IN GENERAL.—Chapter 11 of title 18, United States Code, is amended by adding at the end the following:

"§ 226. Bribery and graft in connection with health care

"(a) Whoever—

"(1) directly or indirectly, corruptly gives, offers, or promises anything of value to a health care official, or offers or promises to give anything of value to any other person, or attempts to violate this subsection, with intent—

"(A) to influence any of the health care official's actions, decisions, or duties relating to a health care benefit program;

"(B) to influence such an official to commit or aid in the committing, or collude in or allow, any fraud, or make opportunity for the commission of any fraud, on a health care benefit program; or

"(C) to induce such an official to engage in any conduct in violation of the lawful duty of such official; or

"(2) being a health care official, directly or indirectly, corruptly demands, seeks, receives, accepts, or agrees to accept anything of value personally or

for any other person or entity, the giving of which violates paragraph (1) of this subsection, or attempts to violate this subsection,

shall be fined under this title or imprisoned not more than 15 years, or both.

"(b) Whoever—

"(1) otherwise than as provided by law for the proper discharge of any duty, directly or indirectly gives, offers, or promises anything of value to a health care official, for or because of any of the health care official's actions, decisions, or duties relating to a health care benefit program, or attempts to violate this subsection; or

"(2) being a health care official, otherwise than as provided by law for the proper discharge of any duty, directly or indirectly, demands, seeks, receives, accepts or agrees to accept anything of value personally or for any other person or entity, the giving of which violates paragraph (1) of this subsection, or attempts to violate this subsection,

shall be fined under this title, or imprisoned not more than 2 years, or both.

"(c) As used in this section—

"(1) the term 'health care official' means—

"(A) an administrator, officer, trustee, fiduciary, custodian, counsel, agent, or employee of any health care benefit program;

"(B) an officer, counsel, agent, or employee, of an organization that provides services under contract to any health care benefit program; or

"(C) an official, employee, or agent of an entity having regulatory authority over any health care benefit program; and

"(2) the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.".

(b) CLERICAL AMENDMENT.—The table of chapters at the beginning of chapter 11 of title 18, United States Code, is amended by adding at the end the following new item:

"226. Bribery and graft in connection with health care.".

SEC. 206. ILLEGAL REMUNERATION WITH RESPECT TO HEALTH CARE BENEFIT PROGRAMS.

(a) IN GENERAL.—Chapter 11 of title 18, United States Code, is amended by adding at the end the following:

"§ 227. Illegal remuneration with respect to health care benefit programs

"(a) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

"(1) in return for referring any individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part by any health care benefit program; or

"(2) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part by any health care benefit program, or attempting to do so,

shall be fined under this title or imprisoned for not more than 5 years, or both.

"(b) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly, or covertly, in cash or in kind to any person to induce such person—

"(1) to refer an individual to a person for the furnishing or arranging for the furnishing of any

item or service for which payment may be made in whole or in part by any health benefit program; or

"(2) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part by any health benefit program or attempts to do so,

shall be fined under this title or imprisoned for not more than 5 years, or both.

"(c) Subsections (a) and (b) shall not apply to—

"(1) a discount or other reduction in price obtained by a provider of services or other entity under a health care benefit program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under a health care benefit program;

"(2) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services if the amount of the remuneration under the arrangement is consistent with the fair market value of the services and is not determined in a manner that takes into account (di-

rectly or indirectly) the volume or value of any referrals;

"(3) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under a health care benefit program if—

"(A) the person has a written contract, with each such individual or entity, which specifies the amount to be paid the person, which amount may be a fixed amount or a percentage of the value of the purchases made by each such individual or entity under the contract, and

"(B) in the case of an entity that is a provider of services (as defined in section 1861(u) of the Social Security Act, the person discloses (in such form and manner as the Secretary of Health and Human Services requires) to the entity and, upon request, to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity;

"(4) a waiver of any coinsurance under part B of title XVIII of the Social Security Act by a feder-

ally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act; and

"(5) any payment practice specified by the Secretary of Health and Human Services in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987.

"(d) Any person injured in his business or property by reason of a violation of this section or section 226 of this title may sue therefor in any appropriate United States district court and shall recover threefold the damages such person sustains and the cost of the suit, including a reasonable attorney's fee.

"(e) As used in this section, 'health care benefit program' has the meaning given such term in section 1347(b) of this title.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 11 of title 18, United States Code, is amended by adding at the end the following:

"227. Illegal remuneration with respect to health care benefit programs.".

(c) CONFORMING AMENDMENT.—Section 1128B of the Social Security Act (42 U.S.C. 1320a–7b) is amended by striking subsection (b).

SEC. 207. OBSTRUCTION OF CRIMINAL INVESTIGATIONS OF HEALTH CARE OFFENSES.

(a) IN GENERAL.—Chapter 73 of title 18, United States Code, is amended by adding at the end the following:

"§ 1518. Obstruction of criminal investigations of health care offenses

"(a) Whoever willfully prevents, obstructs, misleads, delays or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a health care offense to a criminal investigator shall be fined under this title or imprisoned not more than 5 years, or both.

"(b) As used in this section the term 'health care offense' has the meaning given such term in section 24 of this title.

"(c) As used in this section the term 'criminal investigator' means any individual duly authorized by a department, agency, or armed force of the United States to conduct or engage in investigations for prosecutions for violations of health care offenses.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 of title 18, United States Code, is amended by adding at the end the following new item:

"1518. Obstruction of criminal investigations of health care offenses.".

SEC. 208. CIVIL PENALTIES FOR VIOLATIONS OF FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"§ 1348. Civil penalties for violations of Federal health care offenses

"The Attorney General may bring a civil action in the appropriate United States district court against any person who engages in conduct constituting a violation of Federal health care offense, as that term is defined in section 24 of this title and, upon proof of such conduct by a preponderance of the evidence, such person shall be subject to a civil penalty of not more than $50,000 for each violation or the amount of compensation or proceeds which the person received or offered for the prohibited conduct, whichever amount is greater. The imposition of a civil penalty under this section does not preclude any other criminal or civil statutory, common law, or administrative remedy, which is available by law to the United States or any other person.".

(b) CLERICAL AMENDMENT.—The table of sections for chapter 63 of title 18, United States Code, is amended by adding at the end the following item:

"1348. Civil penalties for violations of Federal health care offenses.".

SEC. 209. INJUNCTIVE RELIEF RELATING TO HEALTH CARE OFFENSES.

Section 1345(a)(1) of title 18, United States Code, is amended—

(1) by striking "or" at the end of subparagraph (A);

(2) by inserting "or" at the end of subparagraph (B); and

(3) by adding at the end the following:

"(C) committing or about to commit a Federal health care offense (as defined in section 24 of this title).".

SEC. 210. AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.

(a) IN GENERAL.—Chapter 233 of title 18, United States Code, is amended by adding after section 3485 the following:

"§ 3486. Authorized investigative demand procedures

"(a) AUTHORIZATION.—(1) In any investigation relating to functions set forth in paragraph (2), the Attorney General or the Director of the Federal Bureau of Investigation or their designees may issue in writing and cause to be served a summons compelling the attendance and testimony of witnesses and requiring the production of any records (including any books, papers, documents, electronic media, or other objects or tangible things), which

may be relevant to an authorized law enforcement inquiry, that a person or legal entity may possess or have care, custody, or control. The attendance of witnesses and the production of records may be required from any place in any State or in any territory or other place subject to the jurisdiction of the United States at any designated place of hearing; except that a witness shall not be required to appear at any hearing more than 500 miles distant from the place where he was served with a subpoena. Witnesses summoned under this section shall be paid the same fees and mileage that are paid witnesses in the courts of the United States. A summons requiring the production of records shall describe the objects required to be produced and prescribe a return date within a reasonable period of time within which the objects can be assembled and made available.

"(2) Investigative demands utilizing an administrative summons are authorized for:

"(A) Any investigation with respect to any act or activity constituting an offense involving a Federal health care offense as that term is defined in section 24 of title 18, United States Code.

"(B) Any investigation, with respect to violations of sections 1073 and 1074 of title 18, United States Code, or in which an individual has been law-

fully charged with a Federal offense and such individual is avoiding prosecution or custody or confinement after conviction of such offense or attempt.

"(b) SERVICE.—A subpoena issued under this section may be served by any person designated in the subpoena to serve it. Service upon a natural person may be made by personal delivery of the subpoena to him. Service may be made upon a domestic or foreign corporation or upon a partnership or other unincorporated association which is subject to suit under a common name, by delivering the subpoena to an officer, to a managing or general agent, or to any other agent authorized by appointment or by law to receive service of process. The affidavit of the person serving the subpoena entered on a true copy thereof by the person serving it shall be proof of service.

"(c) ENFORCEMENT.—In the case of contumacy by or refusal to obey a subpoena issued to any person, the Attorney General may invoke the aid of any court of the United States within the jurisdiction of which the investigation is carried on or of which the subpoenaed person is an inhabitant, or in which he carries on business or may be found, to compel compliance with the subpoena. The court may issue an order requiring the subpoenaed person to appear before the Attorney General to produce records, if so ordered, or to give testimony touching the matter

under investigation. Any failure to obey the order of the court may be punished by the court as a contempt thereof. All process in any such case may be served in any judicial district in which such person may be found.

"(d) IMMUNITY FROM CIVIL LIABILITY.—Notwithstanding any Federal, State, or local law, any person, including officers, agents, and employees, receiving a summons under this section, who complies in good faith with the summons and thus produces the materials sought, shall not be liable in any court of any State or the United States to any customer or other person for such production or for nondisclosure of that production to the customer.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 223 of title 18, United States Code, is amended by inserting after the item relating to section 3485 the following new item:

"3486. Authorized investigative demand procedures.".

(c) CONFORMING AMENDMENT.—Section 1510(b)(3)(B) of title 18, United States Code, is amended by inserting "or a Federal Bureau of Investigation summons (issued under section 3486 of title 18)," after "subpoena".

SEC. 211. GRAND JURY DISCLOSURE.

Section 3322 of title 18, United States Code, is amended—

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b) the following:

"(c) A person who is privy to grand jury information concerning a health care offense—

"(1) received in the course of duty as an attorney for the Government; or

"(2) disclosed under rule 6(e)(3)(A)(ii) of the Federal Rules of Criminal Procedure;

may disclose that information to an attorney for the Government to use in any civil investigation or proceeding related to a Federal health care offense (as defined in section 24 of this title).".

SEC. 212. MISCELLANEOUS AMENDMENTS TO TITLE 18, UNITED STATES CODE.

(a) LAUNDERING OF MONETARY INSTRUMENTS.—Section 1956(c)(7) of title 18, United States Code, is amended by adding at the end thereof the following:

"(F) Any act or activity constituting an offense involving a Federal health care offense as that term is defined in section 24 of title 18, United States Code.".

(b) ENHANCED PENALTIES.—Section 2326(2) of title 18, United States Code, is amended by striking "sections

that—" and inserting "or in the case of a Federal health care offense as that term is defined in section 24 of this title, that—".

(c) AUTHORIZATION FOR INTERCEPTION OF WIRE, ORAL, OR ELECTRONIC COMMUNICATIONS.—Section 2516(1)(c) of title 18, United States Code, is amended—

(1) by inserting "section 226 (bribery and graft in connection with health care), section 227 (illegal remunerations)" after "section 224 (bribery in sporting contests),"; and

(2) by inserting "section 1347 (health care fraud)" after "section 1344 (relating to bank fraud)," .

(d) DEFINITIONS.—Section 1961(1) of title 18, United States Code, is amended—

(1) by inserting "sections 226 and 227 (relating to bribery and graft, and illegal remuneration in connection with health care)" after "section 224 (relating to sports bribery),";

(2) by inserting "section 669 (relating to theft or embezzlement in connection with health care)" after "section 664 (relating to embezzlement from pension and welfare funds),"; and

(3) by inserting "section 1347 (relating to health care fraud)" after "section 1344 (relating to financial institution fraud),".

(e) CRIMINAL FORFEITURE.—Section 982(a) of title 18, United States Code, is amended by adding at the end the following new paragraph:

"(6) The court in imposing sentence on a person convicted of a Federal health care offense as defined in section 24 of this title, shall order that the offender forfeit to the United States any real or personal property constituting or derived from proceeds that the offender obtained directly or indirectly as the result of the offense.".

(f) REWARDS FOR INFORMATION LEADING TO PROSECUTION AND CONVICTION.—Section 3059(c)(1) of title 18, United States Code, is amended by inserting "or furnishes information unknown to the Government relating to a possible prosecution of a Federal health care offense as defined in section 24 of this title, which results in a conviction" before the period at the end.

TITLE III—ANTI-FRAUD INITIATIVES UNDER MEDICARE AND MEDICAID

SEC. 301. REVISION TO CURRENT PENALTIES.

(a) PERMISSIVE EXCLUSION OF INDIVIDUALS WITH OWNERSHIP OR CONTROL INTEREST IN SANCTIONED ENTITIES.—Section 1128(b) of the Social Security Act (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

"(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—Any individual who has a direct or indirect ownership or control interest of 5 percent or more, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of, an entity—

"(A) that has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection;

"(B) against which a civil monetary penalty has been assessed under section 1128A; or

"(C) that has been excluded from participation under a program under title XVIII or under a State health care program.".

(b) IMPOSITION OF CIVIL MONETARY PENALTY ON EMPLOYER BILLING FOR SERVICES FURNISHED BY EXCLUDED EMPLOYEE.—Section 1128A(a)(1) of the Social Security Act (42 U.S.C. 1320a–7a(a)(1)) is amended—

(1) by striking "or" at the end of subparagraph (C);

(2) by striking "; or" at the end of subparagraph (D) and inserting ", or"; and

(3) by adding at the end the following new subparagraph:

"(E) is for a medical or other item or service furnished by an individual who is an employee or agent of the person during a period in which such employee or agent was excluded from the program under which the claim was made on any of the grounds for exclusion described in subparagraph (D);".

(c) DEPOSIT OF PENALTIES INTO HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—Section 1128A(f)(3) of such Act (42 U.S.C. 1320a–7a(f)(3)) is amended by striking "as miscellaneous receipts of the Treasury of the United States" and inserting "in the Health Care Fraud and Abuse Control Account established under section 104 of the Health Care Fraud and Abuse Prevention Act of 1995".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to sanctions imposed for acts or omissions occurring on or after the date of the enactment of this Act.

SEC. 302. SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.

(a) IN GENERAL.—

(1) SOLICITATION OF PROPOSALS FOR SAFE HARBORS.—Not later than one year after the date of the enactment of this Act and not less than every 2 years thereafter, the Secretary of Health and Human Services (hereafter in this title referred to as the "Secretary") shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for—

(A) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987; and

(B) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) of the Social Security Act and shall not serve as the

basis for an exclusion under section 1128(b)(7) of such Act.

(2) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL SAFE HARBORS.—After considering the proposals described in paragraph (1), the Secretary, in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received during this period, the Secretary shall issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

(3) REPORT.—The Inspector General of the Department of Health and Human Services (hereafter in this section referred to as the "Inspector General") shall, in an annual report to Congress or as part of the year-end semiannual report required by section 5 of the Inspector General Act of 1978, describe the proposals received under paragraph (1) and explain which proposals were included in the publication described in paragraph (2), which proposals were not included in that publication, and the

reasons for the rejection of the proposals that were not included.

(b) CRITERIA FOR MODIFYING AND ESTABLISHING SAFE HARBORS.—In modifying and establishing safe harbors under subsection (a)(2), the Secretary may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

(1) An increase or decrease in access to health care services.

(2) An increase or decrease in the quality of health care services.

(3) An increase or decrease in patient freedom of choice among health care providers.

(4) An increase or decrease in competition among health care providers.

(5) An increase or decrease in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

(6) An increase or decrease in the cost to health care programs operated or financed by the Federal, State, or local governments.

(7) An increase or decrease in the potential overutilization of health care services.

(8) The existence or nonexistence of any potential financial benefit to a health care professional or provider which may vary based on their decisions of—

(A) whether to order a health care item or service; or

(B) whether to arrange for a referral of health care items or services to a particular practitioner or provider.

(9) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in health care programs operated or financed by the Federal, State, or local governments.

SEC. 303. REQUIRING SECRETARY TO IMPLEMENT PROPOSAL TO EXPEDITE PAYMENT ADJUSTMENTS BASED UPON INHERENT REASONABLENESS.

Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall implement its initiative of December 1994 to expedite the implementation of payment adjustments for covered items under section 1834(a)(10)(B) of the Social Security Act pursuant to the provisions of paragraphs (8) and (9) of section 1842(b) of such Act.

SEC. 304. REQUIRING ANNUAL NOTICE TO MEDICARE BENEFICIARIES OF NEED TO PREVENT FRAUD AND ABUSE AGAINST MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1804(a) of the Social Security Act (42 U.S.C. 1395b–2(a)) is amended—

(1) by striking "and" at the end of paragraph (2);

(2) by striking the period at the end of paragraph (3) and inserting ", and"; and

(3) by inserting after paragraph (3) the following new paragraph:

"(4) a description of the costs to the medicare program of waste, fraud, and abuse, together with suggestions for steps which medicare beneficiaries may take to help combat waste, fraud, and abuse against the program, including the toll-free telephone number operated by the Secretary and the Inspector General of the Department of Health and Human Services for reporting information on fraud and abuse against the program and the potential availability of a reward for individuals reporting information which leads to a criminal prosecution and conviction for health care fraud under title 18, United States Code.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to the annual notice mailed under section 1804(a) of the Social Security Act for years beginning with 1997.

SEC. 305. REQUIRING USE OF SINGLE PROVIDER NUMBER IN SUBMISSION OF CLAIMS FOR PAYMENT UNDER MEDICARE AND MEDICAID.

(a) USE OF SINGLE NUMBER UNDER MEDICARE.—Section 1842(r) of the Social Security Act (42 U.S.C. 1395u(r)) is amended to read as follows:

"(r)(1) Not later than 1 year after the date of the enactment of the Health Care Fraud and Abuse Prevention Act of 1995, the Secretary shall establish a system which provides for a unique identifier for each individual or entity who furnishes items or services for which payment may be made under this part.

"(2) No payment may be made under this title for any item or service furnished by an individual or entity unless the claim for payment with respect to the item or service includes the unique identifier provided to the individual or entity under the system established under paragraph (1).".

(b) PROVIDING MEDICARE NUMBER FOR SUBMISSION OF MEDICAID CLAIMS.—Section 1902(x) of such Act (42 U.S.C. 1396a(x)) is amended—

(1) by striking "(x)" and inserting "(x)(1)"; and

(2) by adding at the end the following new paragraph:

"(2) If an individual or entity submitting a claim to the State for payment for providing medical assistance under the State plan has a unique identifier assigned by the Secretary pursuant to section 1842(r) for purposes of title XVIII, the individual or entity shall include the identifier with such claim.".

SEC. 306. LIABILITY OF CARRIERS AND FISCAL INTERMEDIARIES FOR CLAIMS SUBMITTED BY EXCLUDED PROVIDERS.

(a) REIMBURSEMENT TO SECRETARY FOR AMOUNTS PAID TO EXCLUDED PROVIDERS.—

(1) REQUIREMENT FOR FISCAL INTERMEDIARIES.—

(A) IN GENERAL.—Section 1816 of the Social Security Act (42 U.S.C. 1395h), as amended by section 151(b)(1)(A) of the Social Security Act Amendments of 1994, is amended by adding at the end the following new subsection:

"(l) An agreement with an agency or organization under this section shall require that such agency or organization reimburse the Secretary for any amounts paid for

a service under this title which is furnished by an individual or entity during any period for which the individual or entity is excluded pursuant to section 1128, 1128A, 1156, or subsection (j)(2) from participation in the program under this title, if the amounts are paid after the Secretary notifies the agency or organization of the exclusion.".

(B) CONFORMING AMENDMENT.—Section 1816(i) of such Act (42 U.S.C. 1395h(i)) is amended by adding at the end the following new paragraph:

"(4) Nothing in this subsection shall be construed to prohibit reimbursement by an agency or organization under subsection (l).".

(2) REQUIREMENT FOR CARRIERS.—Section 1842(b)(3) of such Act (42 U.S.C. 1395u(b)(3)), as amended by section 151(b)(1)(B) of the Social Security Act Amendments of 1994, is amended—

(A) by striking "and" at the end of subparagraph (I); and

(B) by inserting after subparagraph (I) the following new subparagraph:

"(J) will reimburse the Secretary for any amounts paid for an item or service under this part which is furnished by an individual or entity during

any period for which the individual or entity is excluded pursuant to section 1128, 1128A, 1156, or subsection (j)(2) from participation in the program under this title, if the amounts are paid after the Secretary notifies the carrier of the exclusion; and".

(b) CONFORMING REPEAL OF MANDATORY PAYMENT RULE.—Section 1862(e)(2) of such Act (42 U.S.C. 1395y(e)(2)) is amended to read as follows:

"(2) No individual or entity may bill (or collect any amount from) any individual for any item or service for which payment is denied under paragraph (1). No person is liable for payment of any amounts billed for such an item or service in violation of the previous sentence. If an individual or entity knowingly and willfully bills (or collects an amount) for such an item or service in violation of such sentence, the Secretary may apply sanctions against the individual or entity in the same manner as the Secretary may apply sanctions against a physician in accordance with subsection (j)(2) in the same manner as such section applies with respect to a physician. Paragraph (4) of subsection (j) shall apply in this paragraph in the same manner as such paragraph applies to such section.".

SEC. 307. STUDY OF FINANCIAL SOLVENCY AND INTEGRITY STANDARDS FOR PROVIDERS AND SUPPLIERS.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the feasibility and desirability of imposing qualifications on individuals and entities providing items and services for which payment may be made under the medicare and medicaid programs relating to financial solvency and fiscal integrity to protect the programs from waste, fraud, and abuse.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the study conducted under subsection (a), and shall include in the report such recommendations as the Secretary considers appropriate for financial solvency and fiscal integrity standards for providers and suppliers under the medicare and medicaid programs..

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Mr. SHAYS. I welcome our chairman of the committee, but before calling on him, I am pleased to call on my ranking member, a gentleman who has been involved in this issue for a long time and has had a tremendous impact, Mr. Towns.

Mr. TOWNS. Let me just say, thanks a lot, Mr. Chairman, but I am prepared to yield to the chairman of the full committee.

Mr. CLINGER. No, go ahead, please.

Mr. TOWNS. Mr. Chairman, thank you for convening today's legislative hearing on two important bills that will significantly improve Federal enforcement of Medicare and Medicaid fraud and abuse and save taxpayers billions of dollars in unnecessary spending under finance and delivery of health care.

H.R. 1850 and H.R. 2326 both are the result of oversight work initiated during the 103d Congress and continued under the leadership of you, Mr. Chairman. This oversight has established the extent of fraud and abuse in the Federal health care system, the effectiveness of current enforcement efforts, and opportunities to improve enforcement of fraud and abuse violations.

H.R. 1850, which I introduced 4 months ago, is virtually the same legislation that I offer along with my colleague, Mr. Schiff, of New Mexico. That amendment actually enjoyed the unanimous support of this committee and nearly unanimous support of the full committee.

H.R. 2326 was introduced earlier this month, again by Mr. Schiff and Subcommittee Chairman Mr. Shays, and successfully incorporates provisions of my bill that enhance coordination of Federal, State, and local enforcement efforts, and establishes supplemental resources to carry out enforcement activities. However, H.R. 2326 also includes significant new provisions that create and define Federal criminal offenses and adjust sections of the Medicare and Medicaid programs to enhance the prevention and detection of health care fraud.

Chairman Shays, I am pleased to be an original cosponsor of H.R. 2326, which I think appropriately builds on my legislation as well as the hearing record. However, while I am encouraged that this bill can create a comprehensive structure for the detection, investigation, and prosecution of health care fraud, I am open to any suggestions from our witnesses today that can improve this legislation. I think, when we think of fraud and abuse, anything that we can come up with that is going to curtail, I think we should try to find a way to support it.

I regret that we were unable to have anyone from the Office of the Inspector General of the Department of Health and Human Services here today to participate in the exchange of views. May I add that they have been very cooperative, Mr. Chairman, and I hope that you would leave the record open for 5 days for additional comments. Also, I would like to ask for permission to place a statement in the record which has been submitted by the Department, as well.

Finally, Mr. Chairman, given the increasing likelihood that we will see drastic cuts in Federal support for Medicare and Medicaid in the near future, it may be that our most responsible contribution to Medicare and Medicaid reform, as subcommittee members, will

be to craft legislation that curbs the rampant fraud and abuse in the Federal health care system and protects Federal resources.

For this reason, I firmly endorse the concept and goals of these bills and look forward to working closely with you in strengthening this bipartisan legislation. I think it's something that's time is long overdue.

Thank you very much, and I yield back.

[The prepared statement of Hon. Edolphus Towns follows:]

OPENING STATEMENT OF REP. ED TOWNS
BEFORE THE GOVERNMENT REFORM AND OVERSIGHT
SUBCOMMITTEE ON
HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS

Legislative Hearing

H.R. 1850, the "Health Care Fraud and Abuse Act of 1995"
H.R. 2326, the "Health Care Fraud and Abuse Prevention Act of 1995"

September 28, 1995

MR. CHAIRMAN, THANK YOU FOR CONVENING TODAY'S LEGISLATIVE HEARING ON TWO IMPORTANT BILLS THAT WILL SIGNIFICANTLY IMPROVE FEDERAL ENFORCEMENT OF MEDICARE AND MEDICAID FRAUD AND ABUSE, AND SAVE TAXPAYERS BILLIONS OF DOLLARS IN UNNECESSARY SPENDING ON THE FINANCING AND DELIVERY OF HEALTH CARE.

BOTH H.R. 1850 AND H.R. 2326 ARE THE RESULT OF OVERSIGHT WORK, INITIATED DURING MY CHAIRMANSHIP IN THE 103RD CONGRESS AND CONTINUED UNDER THE LEADERSHIP OF CHAIRMAN SHAYS. THIS OVERSIGHT HAS ESTABLISHED THE EXTENT OF FRAUD AND ABUSE IN THE FEDERAL HEALTH CARE SYSTEM, THE EFFECTIVENESS OF CURRENT ENFORCEMENT EFFORTS, AND OPPORTUNITIES TO IMPROVE ENFORCEMENT OF FRAUD AND ABUSE VIOLATIONS.

H.R. 1850, WHICH I INTRODUCED FOUR MONTHS AGO, IS VIRTUALLY THE SAME LEGISLATION THAT I OFFERED ALONG WITH THEN RANKING MEMBER OF THE SUBCOMMITTEE, MR. SCHIFF, AS AN AMENDMENT TO THE ADMINISTRATION'S HEALTH CARE REFORM PACKAGE IN THE 103RD CONGRESS. THAT AMENDMENT ENJOYED THE UNANIMOUS SUPPORT OF THIS SUBCOMMITTEE, AND THE NEARLY UNANIMOUS SUPPORT OF THE FULL COMMITTEE.

H.R. 2326 WAS INTRODUCED EARLY THIS MONTH BY REP. SCHIFF AND SUBCOMMITTEE CHAIRMAN SHAYS, AND SUCCESSFULLY INCORPORATES PROVISIONS OF MY BILL THAT ENHANCE COORDINATION OF FEDERAL, STATE AND LOCAL ENFORCEMENT EFFORTS, AND ESTABLISHES SUPPLEMENTAL RESOURCES TO CARRY OUT ENFORCEMENT ACTIVITIES. HOWEVER, H.R. 2326 ALSO INCLUDES SIGNIFICANT NEW PROVISIONS THAT CREATE AND DEFINE FEDERAL CRIMINAL OFFENSES, AND ADJUST SECTIONS OF THE MEDICARE AND MEDICAID PROGRAMS TO ENHANCE IN THE PREVENTION AND DETECTION OF HEALTH CARE FRAUD.

CHAIRMAN SHAYS, I AM PLEASED TO BE AN ORIGINAL CO-SPONSOR OF H.R. 2326 WHICH I THINK APPROPRIATELY BUILDS ON MY LEGISLATION AS WELL AS THE HEARING RECORD. HOWEVER, WHILE I AM ENCOURAGED THAT THIS BILL CAN CREATE A COMPREHENSIVE STRUCTURE FOR THE DETECTION, INVESTIGATION, AND PROSECUTION OF HEALTH CARE FRAUD, I AM OPEN TO ANY SUGGESTIONS FROM OUR WITNESSES TODAY THAT CAN IMPROVE THIS LEGISLATION.

IN PARTICULAR, I AM INTERESTED IN HEARING FROM MR. STERN FROM THE JUSTICE DEPARTMENT ABOUT WHAT RAMIFICATIONS YOU ANTICIPATE THE BILL WILL HAVE ON YOUR ENFORCEMENT EFFORTS. MS. BURGESS, MR. MAHON, AND MR. SCHATZ, I ALSO WELCOME YOUR VIEWS ON THE BENEFITS OR SHORTCOMINGS OF THIS LEGISLATION. I REGRET THAT WE ARE UNABLE TO HAVE ANYONE FROM THE OFFICE OF THE INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES HERE TODAY TO PARTICIPATE IN THIS EXCHANGE OF VIEWS.

FINALLY, MR. CHAIRMAN, GIVEN THE INCREASING LIKELIHOOD THAT WE WILL SEE DRASTIC CUTS IN FEDERAL SUPPORT FOR MEDICARE AND MEDICAID IN THE NEAR FUTURE, IT MAY BE THAT OUR MOST RESPONSIBLE CONTRIBUTION TO MEDICARE/MEDICAID REFORM AS SUBCOMMITTEE MEMBERS WILL BE TO CRAFT LEGISLATION THAT CURBS THE RAMPANT FRAUD AND ABUSE IN THE FEDERAL HEALTH CARE SYSTEM AND PROTECTS FEDERAL RESOURCES. FOR THIS REASON, I FIRMLY ENDORSE THE CONCEPT AND GOALS OF THESE BILLS, AND LOOK FORWARD TO WORKING CLOSELY WITH YOU IN STRENGTHENING THIS BIPARTISAN LEGISLATION.

Mr. SHAYS. I thank the gentleman.

At this time, I would call on the chairman of the full committee, Mr. Clinger.

Mr. CLINGER. Thank you very much, Mr. Shays.

I just want to associate myself with the remarks of Mr. Towns. This is a significant thing that we can do, in the Government Reform and Oversight Committee, to address the critical problem that we have with Medicare and the fact that it is threatened to go broke within the next 7 years. This is something that we can do here that will be most constructive in addressing that problem.

So I want to, first of all, commend you, Chairman Shays, Mr. Schiff, and also Mr. Towns, for the leadership that you all have shown in crafting this legislation, the Health Care Fraud and Abuse Prevention Act, and for bringing it expeditiously to the subcommittee today. I think, as Mr. Towns has said, it really does represent a bipartisan effort to address what is clearly an extremely serious problem.

This bill is the result of your efforts, Mr. Chairman, in holding a series of hearings conducted to examine the problem of waste and fraud in the Medicare and Medicaid programs. As a number of people have stated at previous hearings, we estimate that Medicare and Medicaid fraud will cost us about $26 billion this year alone because of fraudulent activities.

This activity, without question, drives up the cost of these programs and makes it increasingly difficult for all individuals to afford or to get quality health care. So, despite this very alarming fact, the Government has not taken full advantage of the anti-fraud statutes which allow the Government to exclude fraudulent providers from participating in the Medicare program. This is one of the areas that you have, I think, very well addressed in this legislation.

We have heard testimony from members on both sides of the aisle, the Health Care Financing Administration, General Accounting Office, and others, and the bill that you and Mr. Schiff have drafted I consider to be a very well-balanced, forthright bill to address this very serious problem. I am also pleased to be an original cosponsor of H.R. 2326.

What this legislation does, most significantly, is to establish, for the first time, health care fraud as a Federal crime. I think that is the centerpiece, if you will, of this legislation. It sets out specific penalties for perpetrating fraud. I think it will make it easier for the Government to prosecute, while making it harder for excluded providers to continue doing business with the Government. By establishing civil penalties, exclusion and jail time as real possibilities to fraudulent providers, this legislation will serve as a valuable deterrent against health care fraud.

As I indicated, addressing this issue of fraud and abuse is especially important now, given the efforts of this Congress to really ensure the safety of Medicare, to save it from bankruptcy, and rein in the unsustainable growth rates of the program. Indeed, I think cracking down on fraud and abuse is certainly a priority of the constituents that I have talked with as I travel my district, and they have identified that as a first step in any plan to save the Medicare system.

Obviously, to the extent that we can reduce that $26-billion fraud and abuse price tag, the less we will have to do in terms of considering curtailing or limiting any kind of services that are presently provided.

So I would just point out also, Mr. Chairman, that, as I understand it, your legislation is supported by the Health and Human Services Inspector General, the General Accounting Office, and the National Health Care Anti-Fraud Association. I think you are to be commended for introducing this legislation and moving expeditiously to see it enacted.

Thank you.

[The prepared statement of Hon. William F. Clinger follows:]

Opening Statement of William F. Clinger, Jr.
Chairman
Committee on Government Reform and Oversight
Subcommittee on Human Resources and Intergovernmental Relations
Hearing on H.R. 2326 - The Health Care Fraud and Abuse Prevention Act of 1995
September 28, 1995

At the outset, I would like to commend Chairman Shays and Congressman Schiff for their work in drafting H.R. 2326 -- the *Health Care Fraud and Abuse Prevention Act* and for bringing it before the Subcommittee today. H.R. 2326 truly represents a bi-partisan effort to address a serious problem, and I also want to thank everyone who contributed to the bill.

The legislation we have before us today -- the Health Care Fraud and Abuse Prevention Act of 1995 -- is the result of a series of hearings conducted by this Subcommittee to examine the problem of waste and fraud in the Medicare and Medicaid programs.

As I stated at one of the hearings earlier this year, it is estimated that Medicare and Medicaid will lose approximately $26 billion this year alone to fraudulent activities. Without question, fraudulent activity drives up the cost of these programs and makes it increasingly difficult for all individuals to afford quality health care. Despite this alarming fact, the government has not taken full advantage of anti-fraud statutes which allow the government to "exclude" fraudulent providers from participating in the Medicare program.

After hearing testimony from members on both sides of the aisle, the Health Care Financing Administration, the General Accounting Office, and others, Chairman Shays and Mr. Schiff have drafted what I consider to be a well-balanced, forthright bill to address this very serious problem. I am pleased to be an original sponsor of H.R. 2326.

What this legislation does, for the first time, is establish health care fraud as a federal crime, and it sets out specific penalties for perpetrating fraud. As a result, H.R. 2326 will make it easier for the government to prosecute while making it harder for excluded providers to continue doing business with the government. By establishing civil penalties, "exclusion" and jail time as real

possibilities to fraudulent providers, this legislation will serve as a valuable deterrent against health care fraud.

The bill also calls for coordination between the Inspectors General, Attorney General and State agencies to establish a joint program to prevent, detect and control health care fraud. Increased coordination between all responsible agencies will enable the government to have significantly greater success in fighting fraud.

Addressing health care fraud and abuse is particularly important now given Congress's efforts to save Medicare from bankruptcy and reign in the unsustainable growth rates of the program. Indeed, cracking down on fraud and abuse is a priority that my own constituents have identified as an important first step in any plan to save the Medicare system.

Finally, I would like to point out that H.R. 2326 is supported by the Health and Human Services Inspector General, the General Accounting Office, and the National Health Care Anti-Fraud Association.

I want to again thank Chairman Shays and Congressman Schiff for their efforts to bring this legislation before the Subcommittee today.

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Mr. SHAYS. I thank the gentleman.

The vice chairman, Mr. Souder: do you have any comments?

Mr. SOUDER. I have no formal statement. I, too, want to congratulate the chairman and Mr. Schiff and Mr. Towns for their leadership and for the hearings we have been through. They have been exasperating to me, as they are to the constituents in Indiana and other places who are concerned about the fraud, and I appreciate your efforts.

Mr. SHAYS. I thank the gentleman.

The author of this legislation, Mr. Schiff.

Mr. SCHIFF. Mr. Chairman, I am mindful of the fact that we have witnesses, but I would like just a few minutes here for an opening statement.

Mr. SHAYS. Sure.

Mr. SCHIFF. I just want to say, first, we all know the seriousness of the problems of fraud, waste, and abuse, victimizing the whole health care system, as well as Medicare, in particular.

Second, I want to emphasize what has already been said now several times ahead of me but is worth emphasizing again, nobody supports fraud, waste, and abuse. There is no reason for partisanship on this issue. We might disagree on other policy matters; there is no reason for policy disagreement here.

I want to stress that, in putting together H.R. 2326, I worked closely with you and your staff. I took elements that Mr. Towns and I had drafted together when I served as ranking member of this subcommittee. I talked with officials from the Clinton administration agencies and got all of the input I could, because I think that we all need to work together on this.

I want to briefly state how H.R. 2326 is put together. It is put together, essentially, in three parts. The first part is an exact duplication of the amendment to the health care bill that Congressman Towns and I wrote last year. In the second part of the bill are proposed changes in the criminal law, which I put together after talking with numerous law enforcement agencies who deal with health care fraud. And the third provision came largely from suggestions from the Department of Health and Human Services on what would improve their operation.

I want to conclude by stating that not only do I think that there is no room for partisanship in this, I think there is no room for pride of authorship. Since there are a number of different bills, I think it would be fine to take the best of all bills. H.R. 2389 was introduced on September 21 by Congressman Thomas. It is my understanding that that bill may be included in the Budget Reconciliation Act. It deals with the same subject.

I have contacted the Ways and Means Committee and brought H.R. 2326, our bill, to their attention, because there is no conflict between the two bills. I think they address some issues and we address some issues. The bills are quite compatible with each other. And I have invited the Ways and Means Committee to take our bill, or such portions of the bill that they think they want to move with at this time, in a combined anti-fraud provision in the Budget Reconciliation Act.

I will just conclude, finally, with Mr. Towns' statement that I am willing to talk with everybody on this issue. And if there are pro-

posals on how H.R. 2326 can be improved, I would very much welcome hearing them.

Thank you very much, Mr. Chairman.

Mr. SHAYS. I thank the gentleman.

Mr. Chrysler.

Mr. CHRYSLER. I would just add that, certainly during town hall meetings that I had in my district, we heard testimony that 86 percent of the Medicare bills had errors in them, as they put it. And the $44 billion in waste, fraud, and abuse definitely needs to be addressed. It's the kind of thing that if we don't address them, obviously, the fact that they are going on gives Government a very, very bad name, and we're here to clean that up, and I applaud Mr. Schiff's efforts in this.

Thank you.

Mr. SHAYS. I thank the gentleman.

Without objection, the statement of Representative Cardiss Collins will be made part of the record.

[The prepared statement of Hon. Cardiss Collins follows:]

OPENING STATEMENT OF REP. CARDISS COLLINS
BEFORE THE GOVERNMENT REFORM AND OVERSIGHT
SUBCOMMITTEE ON
HUMAN RESOURCES AND INTERGOVERNMENTAL
RELATIONS

HR 1850 - the Health Care Fraud and Abuse Act of 1995
HR 2326 - the Health Care Fraud and Abuse Prevention Act of 1995

September 28, 1995

Mr. Chairman, I am pleased to join you at this legislative hearing. Under consideration this morning are two bills that seek to improve Federal enforcement of health care fraud and abuse violations in the Medicare and Medicaid programs: H.R. 1850, the "Health Care Fraud and Abuse Act of 1995" and H.R. 2326, the "Health Care Fraud and Abuse Prevention Act of 1995". I endorse the goals of these bills, and I appreciate the bipartisan spirit with which these measures have been developed.

The issue is whether this hearing is at all relevant considering the Republican-sponsored plan to overhaul the Medicare and Medicaid systems and cut Federal support for these programs by over $450 billion in seven years. Mr. Chairman, neither H.R. 1850 or H.R. 2326 are included in the Republican-sponsored Medicare reform proposals which are under active consideration in the House Ways and Means and Senate Finance Committees. Furthermore, Medicaid reform legislation reported out of the House Commerce Committee last week, and now being rushed to the Floor, did not contain any of the provisions in H.R. 1850 and H.R. 2326.

I am also concerned that the Medicaid plan may create incentives for more fraud. Under the plan, States would receive a lump sum Federal payment with maximum flexibility to decide how the Federal dollars are spent, and minimum Federal restrictions. This new "MediGrant" plan could result in less Federal oversight of State-run health benefits programs and more fraud and abuse violations at the State level. Second, Federal spending cuts of $180 billion in Medicaid over seven years will increase costs to States and may result in reduced State spending on health care fraud and abuse control efforts.

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Having expressed these serious concerns, Mr. Chairman, let me close by affirming my support for the goals of H.R. 1850 and H.R. 2326 as real remedies to the chronic problems of fraud and abuse in the Medicare and Medicaid programs. I look forward to working closely with you and the ranking Democrat of the Subcommittee, Mr. Towns, in strengthening this bipartisan legislation.

CAP

Mr. SHAYS. I just would say, before calling on our witnesses, that this truly is a team effort. We have had both administrations in control of HHS, so we're not throwing stones at this administration. There are things that could have happened in the last administration. We are just going to all try to start from this point on and see what we can accomplish.

So, at this time, I invite Dr. Helen Smits. If you would remain standing, I will be swearing you in. I believe you are accompanied by Bill Gould. Dr. Smits is the deputy administrator, Health Care Financing Administration, and a Connecticut resident, which gives her a special advantage.

Are you accompanied by anyone, or are you on your own?

Dr. SMITS. Mr. Gould is here.

Mr. SHAYS. Why don't you have him come up. This way, if we could, Mr. Gould, if you want to respond directly to a question that, Dr. Smits, you would like to give him, then he is sworn in.

As is our custom, we swear in everyone. Would you raise your right hands.

[Witnesses sworn.]

Mr. SHAYS. For the record, both witnesses have responded in the affirmative.

I would like to just get a little housekeeping out of the way. I would ask unanimous consent that the hearing record remain open for 7 days.

Does the gentleman have a question?

Mr. TOWNS. I don't have a question, Mr. Chairman. Gerald Stern is here.

Mr. SHAYS. Oh, I'm sorry. I wish I had been told that before.

Mr. Stern, you are going to be sworn in as an individual, so if you would come up, too.

I just moved so quickly my staff couldn't pull me down. For future reference, you just say, "Hey, idiot, you've got another person." [Laughter.]

You can include that in the record.

[Witness sworn.]

Mr. SHAYS. Thank you, Mr. Stern.

Mr. TOWNS. Before we get started, Mr. Gould, are you from Brooklyn?

Mr. GOULD. No, I'm not.

Mr. TOWNS. I'm just trying to balance this thing here. [Laughter.]

Mr. SHAYS. We are going to ask unanimous consent that the hearing record remain open for 7 days to permit the inclusion of the statements from the HHS IG, the National Association of Attorneys General, and the National Association of Medicaid Fraud Control Units. These statements will be distributed to all members.

Without objection, so ordered.

[The information referred to follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

SEP 27 1995

The Honorable Christopher Shays, Chairman
Subcommittee on Human Resources and Intergovernmental Affairs
Committee on Government Reform and Oversight
House of Representatives
Washington, D.C. 20515

Dear Mr. Shays:

The Inspector General, June Gibbs Brown, is very appreciative of your invitation to testify at the hearing before your Subcommittee to be held on September 28. Were it not for a prior commitment in another city, she would have been happy to deliver testimony in person. Since Ms. Brown cannot be in Washington on the day of the hearing, we request your permission to submit the enclosed statement for the record as an alternative.

The Office of Inspector General (OIG) statement endorses the provisions of H.R. 2326, the Health Care Fraud and Abuse Prevention Act of 1995, sponsored by Representative Steven Schiff and you and describes some suggestions through which the bill could be made even stonger in curbing fraud in Federal health care programs. We have also referred positively to similar provisions in H.R. 1850 sponsored by Representative Edolphus Towns, the Ranking Minority Member. For example, we strongly endorse the proposals in H.R. 2326 and H.R. 1850 to establish a new and comprehensive fraud and abuse control program applicable to all payers. In our statement, we have addressed in particular the following provisions in H.R. 2326 that expand current authorities of the Inspector General:

- to impose strict liability upon employers who hire and bill for the services of individuals who have been excluded from participation in Government health care programs; and

- to impose a new permissive exclusion authority against individuals who own or control sanctioned entities.

Along with other provisions, we also endorse requiring carriers and fiscal intermediaries to reimburse the Medicare Trust Funds for any health care program funds paid to excluded providers once the carrier or intermediary has been notified of the exclusion.

On behalf of the Inspector General, I thank you for the time, thought, and attention to detail you and Mr. Schiff and your staffs have given to H.R. 2326 and also convey our appreciation to Mr. Edolphus Towns for inviting us to review and comment on H.R. 1850 as well. We have been positively impressed by the efforts of both the majority and

minority staffs to explore thoughtful and reasoned approaches to some very important changes that are needed in the way we deal with fraud in Federal health care programs.

Sincerely yours,

Michael Mangano

Michael F. Mangano
Principal Deputy Inspector General

enclosure

cc:
The Honorable Edolphus Towns, Ranking Minority Member
Subcommittee on Human Resources and Intergovernmental Affairs
Committee on Government Reform and Oversight
House of Representatives
Washington, D.C. 20515

Statement of
June Gibbs Brown, Inspector General
Department of Health and Human Services

I appreciate the opportunity to comment on H.R. 2326 and H.R. 1850. These bills enhance and strengthen many of the enforcement tools in the Inspector General's arsenal for combatting fraud and abuse--a problem which squanders our limited governmental resources and which can adversely affect our program beneficiaries. At a time when various health care cost savings are being considered by the Congress, efforts to control fraud and abuse are highly appropriate, helping our federally funded health care programs to operate efficiently, economically and effectively.

Coordination and Resources

We strongly endorse the proposals in H.R. 2326 and 1850 to establish a new and comprehensive fraud and abuse control program applicable to all payers. Such a program would strengthen the current efforts of Federal and State governments, as well as private third party payers, to coordinate their enforcement efforts. Ten years ago, the Office of Inspector General (OIG) helped establish the National Health Care Anti-Fraud Association (representing both governmental and private third party payers and law enforcement agencies) to coordinate governmental and private health care fraud enforcement activities. Over the years, this governmental/private partnership group has been extremely successful in fostering collaboration.

Moreover, the OIG has recently established with the Department of Justice and other enforcement agencies an Executive Level Working Group to focus on health care fraud, and we have started to see positive results. However, better communication and coordination of law enforcement activities are clearly needed in the fight against health care fraud and abuse, and your proposed all-payer fraud and abuse control program would foster such activities.

The proposals in H.R. 2326 and H.R. 1850 to establish a Health Care Fraud and Abuse Control Account would also improve our enforcement efforts significantly. We support a mechanism whereby funding to combat fraud and abuse is increased without drawing down from the U.S. Treasury, or burdening taxpayers further. Under the approach suggested in both of these bills, financial recoveries derived from health care fraud cases such as criminal fines, civil penalties and damages under the False Claims Act, and administrative penalties and assessments, would be deposited into an account, to be made available for the future funding of fraud and abuse enforcement activities. This plan makes the individuals who actually perpetrate fraud against, or otherwise abuse our Federal programs, pay the costs of increased enforcement in those programs. We would recommend that the legislation ensure full restitution to government health care programs of monies lost due to fraud, as well as investigative costs incurred by the OIG, before any funds are to be deposited into the account.

Legal Remedies

H.R. 2326 contains several proposals for expanding current criminal, civil and administrative authorities of the OIG. We applaud these efforts to strengthen available legal remedies, which assist us in targeting wrongdoers and provide increased deterrence as well. We are especially interested in

your proposals for enhancing the remedies available to the OIG under the Civil Monetary Penalties Law (CMPL) and the permissive exclusion provisions of the Social Security Act. The CMPL, section 1128A of the Social Security Act, was enacted in 1981 as an alternative administrative remedy to civil prosecution under the False Claims Act. It provides a means to administratively impose civil monetary penalties and assessments, and exclusions from program participation, on individuals and entities who submit false or improper claims for payment to Medicare, Medicaid and the other State health care programs. The permissive exclusion authorities for sanctioning aberrant health care providers, set forth at section 1128(b) of the Social Security Act, allow for the exclusion of individuals or entities from program participation if, under certain criteria, the OIG determines an exclusion to be warranted. Permissive exclusions may be taken based on convictions for non-Medicare/Medicaid health care fraud, State licensing suspensions and revocations, or controlled substance violations.

Amendments to the OIG's CMPL Authorities

We strongly support your proposal to expand the OIG's Civil Monetary Penalty authority to impose strict liability upon employers who hire and bill for the services of individuals who have been excluded from participation in government health care programs. Currently, the CMPL holds an excluded provider strictly liable (i.e., liable without proof of knowledge or intent) for claims submitted, or caused to be submitted, for services that he or she renders while excluded. However, some excluded individuals have continued to treat program beneficiaries, and have improperly caused the Medicare and Medicaid programs to pay for their services, by seeking employment with participating providers who agree to bill for their services. Expanding application of the strict liability standard to the employers of excluded providers will enhance our ability to protect program beneficiaries, while protecting the financial integrity of the programs themselves. Such a provision also encourages health care employers to ascertain the program participation status of employees prior to submitting claims for payment for services rendered, ordered, or directed by such individuals.

An additional amendment to the CMPL that would significantly enhance our enforcement authority would be to expand the reach of the CMPL to include all Federal health care programs. Currently, the CMPL only reaches those who submit or cause the submission of claims to one of four Federal programs: Medicare Medicaid, the Maternal and Child Services Block Grant program, and the Social Services Block Grant program. Thus, under current law, the OIG cannot impose civil monetary penalties and assessments against, for example, someone who submits false claims to the CHAMPUS program or the Federal Employees Health Benefits Program. Modifying the CMPL to apply to health care providers who defraud other Federal health care programs would enable the Government to protect additional beneficiaries from harm, and additional Federal programs from financial loss.

Another modification to the CMPL that would greatly aid our enforcement efforts is extension of the CMPL's strict liability standard to excluded providers who order or prescribe items or services for program beneficiaries, even if they directly furnish no services to beneficiaries. Currently, excluded providers who submit or cause the submission of claims for services furnished during their exclusion periods are strictly liable for those claims. However, we have seen egregious cases of excluded individuals who continue to profit from the Medicare and Medicaid programs by ordering or prescribing items or services from others, such as lab work or pharmaceuticals. Expanding the

CMPL's strict liability standard to excluded providers who do not personally render or direct the provision of health care to program beneficiaries, but who order or prescribe items or services on their behalf, would help the OIG curtail the continuous fraud committed by certain providers. In addition, such a provision will encourage ancillary care providers and suppliers (such as laboratories and pharmacies) to check out providers who refer business to them and to refuse to deal with those who have been excluded from the health care programs.

Amendments to the OIG's Permissive Exclusion Authorities

The OIG's exclusion authorities are an important enforcement remedy. We have made great strides, not only in excluding aberrant providers from our programs, but also in ensuring that they don't continue to abuse our health care financing systems and our beneficiaries. However, there are still some loopholes that allow fraud and abuse to thrive at the expense of the programs, the taxpayers, and program beneficiaries.

The proposal in H.R. 2326 to impose a new permissive exclusion authority against individuals who own or control sanctioned entities closes one such loophole. This new authority would enable the OIG to exclude individuals who own or control entities that have been convicted of program-related crimes, entities against which penalties have been imposed under the CMPL, and entities that have been excluded from Medicare and State health care programs. We have found that unscrupulous health care company owners simply change corporate structures or move from one business to another if the first has been convicted or excluded. As our authority now stands, if an owner is convicted and excluded, then we can exclude any company associated with that individual. However, if a company is excluded, we currently have no authority under which we can take action against the owner of the company. That individual is free to reincorporate or start another business with no fear of exclusion. Your proposal permits the OIG to exclude culpable individuals who move from company to company, shutting the door on these "mobile" business owners.

Additional Anti-Fraud Initiatives

We applaud the proposal in H.R. 2326 to require carriers and fiscal intermediaries to reimburse the Medicare Trust Funds for any health care program funds paid to excluded providers once the carrier or intermediary has been notified of the exclusion. If these contractors fail to take the administrative steps necessary to implement and enforce the OIG's exclusions, they should remain liable for any claims wrongfully paid to an excluded party. By preventing improper disbursements of program funds to individuals and entities not entitled to receive them, this provision should result in substantial savings to the Federal health care programs. However, we recommend that this provision be expanded to impose the same liability upon States that fail to implement the OIG's exclusions. We have had experiences with State Medicaid agencies which have neglected to enforce OIG exclusions in a timely and proper manner. The lesson of these experiences is that a mechanism is needed to ensure that the States respond to the OIG's exclusion notices. Expansion of your legislative proposal affecting carriers and fiscal intermediaries to State Agencies that fail to implement OIG exclusions would provide such a mechanism.

Again, we appreciate having an opportunity to comment on this legislation and will be happy to continue working with your staff on these important issues.

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CHRISTINE T. MILLIKEN
Executive Director
General Counsel

October 5, 1995

Honorable Christopher Shays
Chair
Subcommittee on Human Resources and
Intergovernmental Relations
Committee on Government Reform and
Oversight
Room B-372
Rayburn House Office Building
Washington, D.C. 20515

Re: Statement for the Record--H.R. 2326 and H.R. 1850

Dear Chairman Shays:

Thank you very much for the opportunity to comment on H.R. 2326, the Health Care Fraud and Abuse Prevention Act of 1995 and H.R. 1850, the Health Care Fraud and Abuse Act. Health care fraud is a priority for individual Attorneys General and for the National Association of Attorneys General, and we welcome the opportunity to work with you, Representative Schiff, Representative Towns, and the other members of the Subcommittee to improve law enforcement efforts in this area.

Because time was too short to consult our colleagues, we are not able to speak on behalf of the National Association of Attorneys General, but we would like to offer the following specific comments based on our review of the bills. We have been working closely with Senator Cohen in connection with his bill, S. 1088, and our comments are informed by those discussions. Our comments will be directed to both bills unless otherwise noted.

In general, we very much appreciate your efforts to expand the jurisdiction of and reduce bureaucratic limitations on state Medicaid Fraud Control Units (MFCUs). H.R. 2326 and H.R. 1850 are important steps towards a more coordinated and effective response to health care fraud. As you know, MFCUs, most of which are located in the state Attorney General's office, are responsible for investigating and prosecuting health care fraud by providers in the Medicaid program. The Attorneys General have consistently supported the expansion of MFCU jurisdiction from crimes solely involving the state Medicaid programs to health care provider fraud committed against federally funded programs as well.

Although we believe the legislation moves in the right direction, we have several technical questions about the bills as drafted. First, we believe that the mission statement of the State Health Care Fraud and Abuse Control Units should be clarified. Section 102 of H.R. 2326 (section 2(b) of H.R. 1850) provides that the governor may establish a State agency to act as a Health Care Fraud and Abuse Control Unit. The mission statement for this unit is similar in many ways to that of the existing MFCUs, but the jurisdiction of the Units is broadened to include investigation and prosecution of health care fraud outside the Medicaid program. Because of their structure, mission, and expertise, the Medicaid Fraud Control Units are clearly the most appropriate agencies to undertake these new responsibilities. However, the statute does not specifically redesignate the MFCUs as SHCFACUs, and in fact could be read to create a system with SHCFACUs and MFCUs operating side-by-side. We suggest that this potential confusion be eliminated by simply amending 42 U.S.C. §1396b(q) to redesignate the MFCUs as SHCFACUs and to permit the redesignated Units to undertake the broader anti-fraud responsibilities described in both bills.*

The funding of the SHCFACUs should also be clarified. Section 103 of H.R. 2326 (section 2(c) of H.R. 1850) provides that agencies designated by the Governor will receive a payment equal to 75 percent of the sums expended in preventing, detecting and controlling health care fraud, provided that the state has a State Health Care Fraud and Abuse Control Unit (SHCFACU) that has submitted an annual plan to the Inspector General of the Department of Health and Human Services. However, section 103 does not appear to include the expenses of the SHCFACU itself in the expenses that will be eligible for reimbursement. In light of the SHCFACUs' new responsibilities for investigating and prosecuting every type of health care fraud, we believe that the Units should be reimbursed to at least the same extent as the other state agencies, and in fact, we suggest a reimbursement formula of 90 percent for the first three years for the operations of the SHCFACUs. This type of start-up funding provides an additional incentive for states to undertake the important new functions described in the bills.

We strongly support the creation of a Health Care Fraud and Abuse Control Account which will be available to assist both Federal and state anti-fraud efforts. We believe that the

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*Section 102 provides that the Governor may designate agencies "which conduct, supervise and coordinate audits, civil and criminal investigations, inspections and evaluations relating to prevention, detection and control of health care fraud and abuse in violation of *Federal* law in the state." (emphasis added) We believe that this provision should be modified to read "*state and Federal*" law. In most instances, state Attorney General offices use state law to secure convictions of fraudulent providers. State prosecutors may be cross-designated as federal prosecutors for specific cases, but much of the work against fraud is done under state law. The same comment applies to the use of the term "Federal law" in sections 101(c)(1), 101(d), 102(b)(1)(B), 102(b)(1)(C), 102(b)(2), and 102(c).

Advisory Board established in both bills will benefit from the representation of state prosecutors. However, as chief legal officers of our states, we are concerned about the limitation on prosecutorial discretion contained in section 104(d) of H.R. 2326. Although we recognize that the intention of the provision is to prevent "bounty hunting" and ensure fairness, the prosecutor's judgment as to the remorse of the defendant, the risks of litigation and the benefits of prompt resolution of cases is important, and should not be limited in this way.

The new criminal provisions contained in H.R. 2326 appear to provide effective new tools for the fight against health care fraud. In particular, the new health care fraud offense should be a valuable addition to the current mail and wire fraud offenses frequently used by prosecutors.

Thank you again for giving us an opportunity to comment on H.R. 2326 and H.R. 1850. We look forward to working with you on these bills and future anti-fraud initiatives.

Very truly yours,

Pamela Fanning Carter
Attorney General Pamela Fanning Carter
Chair, NAAG Health Care Task Force

Jeffrey R. Amestoy
Attorney General Jeffrey Amestoy
Vice-Chair, NAAG Health Care Task Force

letters\shays.com

STATEMENT OF

THE NATIONAL ASSOCIATION

OF

MEDICAID FRAUD CONTROL UNITS

PRESENTED TO THE

HOUSE SUBCOMMITTEE ON HUMAN RESOURCES
AND INTERGOVERNMENTAL RELATIONS
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
WASHINGTON, DC

HEARING
OF
SEPTEMBER 28, 1995

The National Association of Medicaid Fraud Control Units is pleased to submit this statement on the role of the states in investigating and prosecuting health care fraud and to specifically address H.R. 2326 and H.R. 1850. As Congress considers methods for controlling health care costs, effective and efficient law enforcement to deter and punish corrupt providers must be an important component in any effort to control and, hopefully, reduce the costs of health care delivery. We appreciate the opportunity to comment on these bills and applaud your efforts to combat health care fraud.

While the investigation and prosecution of health care fraud has only recently become a top national law enforcement priority, the states have been combatting health care fraud for almost two decades and are viewed as leaders in the detection and prosecution of fraud in the health care industry. Medicaid, established by Congress in 1965, is the primary government health care program for approximately 34 million of America's poorest and oldest citizens. For the first decade after Medicaid was created, the system operated with few controls against fraud. Unfortunately, safeguards combined with multi-billion dollar expenditure levels made a substantial amount of fraud inevitable. The result was an unprecedented theft of government dollars as local prosecutors struggled with the difficult task of prosecuting these highly sophisticated crimes. Congress came to recognize an urgent need to address this loss after much media attention and Congressional hearings highlighted the theft of taxpayer dollars and the harm suffered by Medicaid patients who were deprived of basic medical care. The result was legislation to establish specialized state-based strike forces to police the Medicaid program.

In 1977, Congress enacted legislation, the Medicare-Medicaid Anti-Fraud and Abuse Amendments, P.L. 95-142 which established the state Medicaid Fraud Control Unit Program. The objective of this legislation was to strengthen the capability to detect, prosecute and punish health care fraud. In addition to investigating and prosecuting providers who defraud the

Medicaid program, the mandate to Medicaid Fraud Control Units (MFCUs) specifically includes the authority to prosecute the abuse or neglect of patients in all residential health care facilities that are Medicaid providers. The Units are staffed by professional teams of attorneys, investigators and auditors specifically trained in the complex litigation aspects of health care fraud. The enabling federal legislation emphasizes the necessity of having an integrated multi-disciplinary team in one office in order to successfully prosecute these complex financial crimes. The Units are required to be separate and distinct from the state Medicaid programs and are usually located in the state Attorney General's office, although some Units are located in other state agencies with law enforcement responsibilities such as the state police or the state Bureau of Investigation. The Omnibus Reconciliation Act of 1993 required all states to have a Medicaid Fraud Control Unit by this year, unless a state can demonstrate to the Secretary of the Department of Health and Human Services, (HHS) that it has a minimum amount of Medicaid fraud and that residents of health care facilities that receive Medicaid funding will be protected from abuse and/or neglect.

Since the inception of this pioneering program, the state MFCUs have successfully prosecuted over 7,000 corrupt medical providers and vendors and elder abusers -- convictions that would not have occurred without this vital piece of legislation. These 47 Units police 95% of the nation's Medicaid expenditures with combined staff of approximately 1,150 and a total federal budget of $69 million. This funding represents a small fraction of the total Medicaid budget that the Units are responsible for policing. Unit size varies state-by-state and is dictated to some extent by the size of state's Medicaid program.

In addition to the criminal consequences of MFCU cases (repayment of restitution, overpayments, state exclusions, incarceration, and often the loss of certifications, the ability to conduct business and professional licenses) the criminal convictions of the Units become the

basis for further federal actions. The federal actions that are reported to Congress by the Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) include the underlying state convictions, judgments, forfeitures, civil settlements, federal program exclusions, and civil monetary penalties. In fact, the majority of health care fraud convictions, penalties, and exclusions reported to you are based upon MFCU convictions. The MFCUs are the most efficient and effective law enforcement agencies in the battle against health care fraud and patient abuse.

While this remarkable success in detecting and prosecuting Medicaid provider fraud is widely recognized, it is perhaps less well known that the Units are the only law enforcement agencies in the country specifically charged with investigating patient abuse and neglect. Patient abuse can be classified into several categories. For example, providing inadequate medical or custodial care or creating other health care risks may constitute patient neglect. Physical abuse includes acts of violence such as slapping, kicking, hitting or punching a patient and sexual abuse. Financial abuse includes the misappropriation of patients' personal funds such as commingling patient and facility funds or using patient funds to pay for facility operations.

Scores of investigations and years of cumulative experience have made it clear that the abuse, neglect, mistreatment, and economic exploitation of nursing home residents is a problem of far greater magnitude than previously thought. Our national association, in collaboration with the National Association of Attorneys General (NAAG), has therefore promulgated a model patient abuse statute -- already adopted in several states -- that would not only provide the necessary prosecutorial tools and enhanced penal sanctions for combatting this type of shocking misconduct, but would also serve as a powerful deterrent to potential patient abusers.

Congress enacted P.L. 95-142, not only because of the widespread evidence of fraud in the Medicaid Program, but also because of the horrendous tales of nursing home patient abuse and resident victimization -- and the Units are justly proud of their record in protecting the frail and vulnerable institutionalized elderly.

In the past decade, we have seen a rapid increase both in the number of fraudulent schemes and the degree of sophistication with which they are committed. Although the typical fraud schemes such as billing for services never rendered, double billing, misrepresenting the nature of services provided, providing unnecessary services, false cost reports and kickbacks still regularly occur, new and often innovative methods of thievery have continued to appear.

Medicaid fraud cases run the gamut from a solo practitioner who submits claims for services never rendered to large institutions which exaggerate the level of care provided to their patients and then alter patient records in order to conceal that lack of care. MFCUs have prosecuted psychiatrists who have demanded sexual favors from their patients in exchange for prescription drugs, nursing home owners who steal money from residents, and even funeral directors who bill the estates of Medicaid patients for funerals they did not perform.

Over the past few years, these so-called "typical" schemes have given way to more innovative ones. Recently, the Units have identified serious fraud problems in several industries including laboratories, home health care, medical transportation, medical supplies, pharmacies, and imaging centers. The incidence of illegal drug diversion has risen sharply over the years, carrying with it a dramatic financial impact on the Medicaid program.

More and more states are enrolling their Medicaid population into managed care plans. While proponents of the managed care system believe that it is the best method for providing low cost high quality health care to more people, the experience of the fraud units reveal that no health care plan is immune from fraud and indeed fraud does occur in managed care plans.

Recent global settlements of cases involving multiple state and federal entities have encouraged cooperative federal/state efforts to protect the Medicare/Medicaid programs from health care providers or vendors whose activities know no borders.

BLOCK GRANT/ MFCU FUNDING

Under current legislation, Units are funded with 75% federal funds and 25% state matching funds on a yearly grant basis except for the first three years of a Unit's operation when a Unit receives 90% federal funding. 90% federal funding provides an incentive for establishing a fraud control unit and is also intended to provide a new Unit sufficient time to become fully operational. The federal match is part of the Medicaid program's administrative costs, which are contained in the budget of the Health Care Financing Administration (HCFA). The funds for the fraud control units are subsequently transferred to the HHS Office of Inspector General (OIG) for distribution to the states. OIG has administrative oversight responsibility for this grant program and certifies and re-certifies the Units to insure that they comply with federal regulations.

We believe that maintaining program integrity functions are essential if any changes occur in the structure of the Medicaid program. State Medicaid fraud enforcement should continue to be a federal priority in the states' administration of their Medicaid program. Funding for the state Medicaid Fraud Control Units should continue to go to their sponsoring agencies and should not be included as part of a larger Medicaid grant that is distributed to the states.

This continued funding mechanism would maintain the separate and distinct character that has made the Units successful in detecting and prosecuting Medicaid fraud. Federal oversight should continue to be vested with the Office of Inspector General of the Department of Health and Human Services to maintain law enforcement sensitivity on oversight issues.

Separation of MFCUs from the Medicaid agency was considered a critical component of P.L. 95-142, which created the state Medicaid fraud control unit program. Congress recognized that law enforcement functions can best be accomplished by law enforcement agencies. Further, in analyzing the reasons for the Medicaid agency's failure to adequately police the program, Congress recognized that there were inherent obstacles. For example, the responsibility of administering the program necessitates a close association with the provider community. This is incompatible with and detrimental to the policing function.

The MFCU program has many of the currently discussed characteristics of a block grant program. Most significant is the states' ability to adopt individual enforcement approaches. The philosophy of current federal grant oversight is to require each state to maintain the resources necessary to operate an effective and efficient Medicaid Fraud Control Unit. We strongly urge that this practice continue and be a requirement for any future block grant programs involving Medicaid.

If the Medicaid statute is rewritten to block grant Medicaid funds, we believe that the following requirements for state MFCUs, while not all inclusive, should be maintained:

- separate and distinct Unit funding status from the state agency that administers the Medicaid program;
- a strictly defined mission statement reflecting current grant oversight requirements;
- funding and authority to continue patient abuse investigations and prosecutions;
- the Unit should be a single identifiable entity with staffing by experienced attorneys, auditors and investigators;
- federal grant oversight by OIG/HHS; and
- Unit funding levels should be maintained.

H.R. 2326 AND 1850

Our comments on H.R. 2326 and 1850 will primarily address state law enforcement issues since our members are state based law enforcement agencies. For sake of clarity, since both H.R. 2326 and 1850 are similar, when sections of a bill are cited, it will refer to sections of H.R. 2326.

State Enforcement

Section 102 recognizes and provides for state enforcement in the prevention, detection and control of health care fraud and abuse. Section 102(a)(2) provides for the creation of health care fraud and abuse control units subject to the approval of the Governor of each state. At present, 47 states have Medicaid Fraud Control Units, the vast majority of which are housed in a State Attorney General's Office. The Units have been extremely successful in combatting health care fraud over the years, due in no small measure to the clearly defined mission of the Units, i.e., the investigation and prosecution of Medicaid *provider* fraud and patient abuse in facilities funded with Medicaid dollars.

For a number of years, Medicaid Fraud Control Units have been interested in expanding their jurisdiction beyond the Medicaid program, specifically into other federally funded health care programs such as Medicare. Based on the Units' years of experience, a corrupt provider will typically not only defraud the Medicaid program, but will defraud other government and private health care programs at the same time. This year an unprecedented agreement was reached between the National Association of Medicaid Fraud Control Units, the HHS Inspector General's Office, the U.S. Attorney General, and the National Association of Attorneys General to expand the jurisdiction of the Units into Medicare and other federally funded health care programs along with expanding the Units authority to investigate abuse in board and care facilities. This agreement is reflected in S. 1088, Title VI, "The Health Care Fraud and Abuse

Prevention Act of 1995," which was introduced by Senator William Cohen. This expansion of jurisdiction would be cost neutral and would not require additional staff or resources. It is our opinion that H.R. 2326 and 1850 would be best served by adopting the specific language of S. 1088, Section VI, as a substitute for Section 102. (Attached is a copy of Title VI, S. 1088).

We are unclear whether H.R. 2326 and 1850 is intended to expand the jurisdiction of State Health Care Fraud Units and allow these Units to investigate and prosecute private insurance fraud. Historically, the HHS Inspector General's Office, which has oversight over the state MFCUs, has opposed such an expansion. The HHS Inspector General is the sole oversight agency and the United States Attorney General has never had any oversight responsibility over the state MFCUs. Section 102(c) would require health care fraud units to submit yearly plans to not only the Inspector General but to the Attorney General. Further, Section 101 would give the Attorney General and the Inspector General the authority to determine and impose a plan upon state programs to prevent, detect and control health care fraud and abuse. The HHS Inspector General has never imposed such a plan on the states. Due to the successful role that Medicaid Fraud Control Units have played in the fight against health care fraud, the Units should be an equal player with the HHS Inspector General and the Department of Justice. In effect, we should be part of a law enforcement triad. This would best take into consideration the historical state enforcement role and allow for state input into national initiatives.

Section 103(a) would fund, at a 75% level, state agencies designated by the Governor pursuant to Section 102(a)(1) but would not provide funding to state health care fraud and abuse control units pursuant to Section 102(a)(2). Since Section 103(a) refers to Health Care Fraud Units submitting plans to be approved under Section 102(d) by the Inspector General, it would appear that 75% funding is intended for the Health Care Fraud Units and not other state

agencies. If 75% funding applies to other state agencies, Section 102(a)(1) would significantly increase the federal government's cost for existing health care fraud enforcement. Historically, many of the programs that may be contained within this section have not been funded by the federal government. This section could be construed to include, for example, state licensing agencies, state insurance bureaus, and state workers compensation fraud enforcement activities.

As you know, the Units are restricted to investigating and prosecuting provider fraud, not beneficiary fraud. Section 102(a)(1) would allow the Units to prosecute beneficiary fraud. This expansion of authority and responsibility, if it is intended to apply to the MFCUs, would dilute their primary mission of prosecuting provider fraud and would make state health care fraud enforcement less effective and efficient. The mission, funding, and oversight for the MFCUs should be maintained as described in S. 1088.

Health Care Fraud and Abuse Control Accounts

H.R. 2326 and H.R. 1850 establishes a health care fraud and abuse control account to assist in enforcement efforts. We have concerns about whether state prosecutions involving federal health care programs would require the transfer of state money to this account. For example, would state forfeiture proceeds and investigative costs be required to be forwarded to this account? Such a proposal would run afoul of many state laws requiring such monies to be deposited into specific state accounts.

Revisions to Criminal Law and Anti-Fraud Initiatives

We applaud the proposals in H.R. 2326 and 1850 that create new criminal laws for health care fraud. These efforts will assist those in law enforcement to combat fraud and abuse, target wrongdoers and provide increased deterrence. In particular, we applaud the proposed illegal remuneration and obstruction statutes in sections 206 and 207 respectively.

The proposals expanding the Inspector General's civil monetary penalty authority and new permissive exclusion authority will also assist law enforcement. The requirement in section 305 for providers to use a single provider number is excellent and long overdue.

Again, we appreciate the opportunity to comment on this legislation and look forward to working with your staff on these issues.

9-28test

II

104TH CONGRESS
1ST SESSION

S. 1088

To provide for enhanced penalties for health care fraud, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JULY 28 (legislative day, JULY 10), 1995

Mr. COHEN introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To provide for enhanced penalties for health care fraud, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Health Care Fraud and Abuse Prevention Act of 1995".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

"(f) HEALTH PLAN.—As used in this section the term 'health plan' has the same meaning given such term in section 101(c) of the Health Care Fraud and Abuse Prevention Act of 1995.".

(b) CLERICAL AMENDMENT.—The table of sections for chapter 223 of title 18, United States Code, is amended by inserting after the item relating to section 3405 the following new item:

"§ 3486. Authorized investigative demand procedures".

(c) CONFORMING AMENDMENT.—Section 1510(b)(3)(B) of title 18, United States Code, is amended by inserting "or a Department of Justice subpoena (issued under section 3486)," after "subpoena".

TITLE VI—STATE HEALTH CARE FRAUD CONTROL UNITS

SEC. 601. STATE HEALTH CARE FRAUD CONTROL UNITS.

(a) EXTENSION OF CONCURRENT AUTHORITY TO INVESTIGATE AND PROSECUTE FRAUD IN OTHER FEDERAL PROGRAMS.—Paragraph (3) of section 1903(q) of the Social Security Act (42 U.S.C. 1396b(q)) is amended—

(1) by inserting "(A)" after "in connection with"; and

(2) by striking "title." and inserting "title; and

(B) upon the approval of the relevant Federal agen-

cy, any aspect of the provision of health care services and activities of providers of such services under any Federal health care program (as defined in section 1128B(F)(1)).".

(b) EXTENSION OF AUTHORITY TO INVESTIGATE AND PROSECUTE PATIENT ABUSE IN NON-MEDICAID BOARD AND CARE FACILITIES.—Paragraph (4) of section 1903(q) of the Social Security Act (42 U.S.C. 1396b(q)) is amended to read as follows:

"(4)(A) The entity has—

"(i) procedures for reviewing complaints of abuse or neglect of patients in health care facilities which receive payments under the State plan under this title;

"(ii) at the option of the entity, procedures for reviewing complaints of abuse or neglect of patients residing in board and care facilities; and

"(iii) where appropriate, procedures for acting upon such complaints under the criminal laws of the State or for referring such complaints to other State agencies for action.

"(B) For purposes of this paragraph, the term 'board and care facility' means a residential setting which receives payment from or on behalf of two or

more unrelated adults who reside in such facility, and for whom one or both of the following is provided:

"(i) Nursing care services provided by, or under the supervision of, a registered nurse, licensed practical nurse, or licensed nursing assistant.

"(ii) Personal care services that assist residents with the activities of daily living, including personal hygiene, dressing, bathing, eating, toileting, ambulation, transfer, positioning, self-medication, body care, travel to medical services, essential shopping, meal preparation, laundry, and housework.".

TITLE VII—MEDICARE BILLING ABUSE PREVENTION

SEC. 701. IMPLEMENTATION OF GENERAL ACCOUNTING OFFICE RECOMMENDATIONS REGARDING MEDICARE CLAIMS PROCESSING.

(a) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary shall, by regulation, contract, change order, or otherwise, require medicare carriers to acquire commercial automatic data processing equipment (in this title referred to as "ADPE") meeting the requirements of section 702 to

Mr. SHAYS. I also would agree with Mr. Towns that it is unfortunate that we didn't schedule this hearing so the IG could be here. The IG is away, but their testimony is very important. We just felt we needed to move quickly, because we would like to get some of your provisions in our Medicare health bill and also the provisions that have been worked out by Mr. Schiff and others.

So, at this time, Dr. Smits, we welcome your testimony. We will, without objection, include your full statement in the record.

Hearing no objection, so ordered—the statements of any other Member who comes to testify, any witness and any member of this committee, as well—without objection, so ordered.

STATEMENTS OF HELEN SMITS, M.D., DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, ACCOMPANIED BY BILL GOULD, SPECIAL ASSISTANT TO THE ADMINISTRATOR; AND GERALD STERN, SPECIAL COUNSEL FOR HEALTH CARE FRAUD, DEPARTMENT OF JUSTICE

Dr. SMITS. Thank you. It's a pleasure to be here to talk about this very important issue. I will just very briefly summarize my comments.

I would like to begin by saying that Ms. Judy Berek, the special advisor to the administrator on these issues, is very sorry she can't be here today. She had a very recent death in the family and is still in New York. I would also like to say for the record how much I appreciate the qualities Ms. Berek has brought to us in this area. She has a pragmatic, tough-minded approach to fraud that I think has taught us all, and her approach has really improved, over the last year, our approach to this very important issue. I think fraud is like disease, if you don't mind my using a doctor analogy. You can prevent it. You can engage in early detection so that treatment is easy, or, once you have a severe case, you can treat it.

The treating physician is here to my left, and I will leave treatment to him. But I would like to talk a little about some of what we are doing and some of what we are learning about prevention and early detection.

The first element of prevention is that we need to make every effort to ensure that every payment under the Medicare and Medicaid programs is appropriate. The area where we have seen some of the worst problems is in suppliers of durable medical equipment. We have begun a much more rigorous review of qualifications, of whether or not they are legitimate businesses. As a result, as you probably know, we have excluded fairly large numbers of them from the program, particularly in south Florida where we are currently focused.

One area I would like you to think about, though, that worries us, is that, in many cases, businesses dissolve and reappear with a new president, different name, a first cousin is brought in to be the cover. We need ways to track individuals, to identify that there were five owners last time and to see whether any of those owners who have been identified as participating in fraud are participating in the new corporation. I think that is a very important issue in prevention that we are beginning to look at.

Prevention also means better payment methods. We certainly agree that the legislated method we have now for pricing durable

medical equipment is not satisfactory. We should not be paying more than market prices, and we are very eager to work with the appropriate committees on improving payment. I think we have never thought of payment policy as part of fraud prevention before, but it is. It is a very important part.

Legitimate suppliers, if we are paying too much, go ahead and charge us too much, but it does make a very tempting attraction to the illegitimate, and it is important that we focus on that.

Early detection means working collaboratively with the law enforcement agencies to understand the principles, and to understand what we ought to be looking for. It means listening very carefully to beneficiaries and encouraging beneficiaries to tell us when they see trouble. It means using all the eyes and ears we have.

One of Ms. Berek's really important innovations is that we are in the process of training the nursing home surveyors, not to become cops, but to spot potential fraud and to report it to the IG when they spot it. We have eyes out there in a part of the industry where we know there are problems; we need to use those eyes well.

We also are moving into an era of improved computer models and computer methods to detect fraud. We will be starting with a new process called "AdminiStar," which will improve many of the screens that we use on claims, as of January 1. But what we really see is a steady improvement over the next 4 or 5 years.

One of the things that I look forward to the most is that we really are close to the point where you can use high-speed computers and what is called "fuzzy logic," where the computer itself is detecting the aberrant patterns.

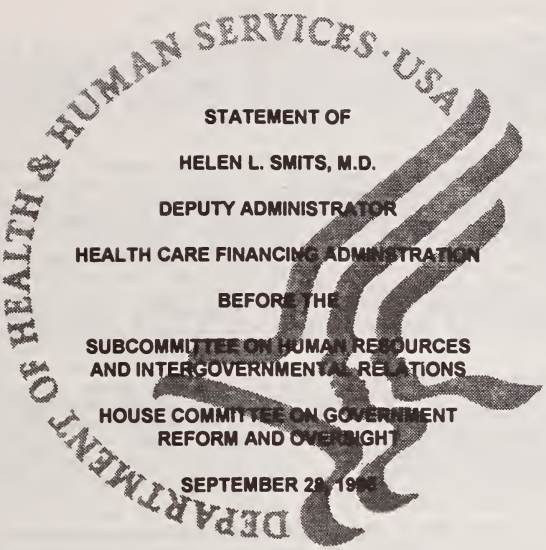
That has great advantages in terms of not allowing the fraudulent provider to learn the pattern he is supposed to avoid. So I think our methods are getting better all the time, and I think we will see marked improvement in that area.

The heart of both prevention and early detection, though, as again Ms. Berek has taught me, is, don't pay and chase. In fact, don't pay when there is a question, because it is easier to hold on to the money than it is to pay it out and recoup it.

So, as I say, I think we are only at the beginning of really getting good at some of this, but with the kind of additional resources in the various bills that have been proposed and the kind of continued collaboration across agencies that we have started without mandates, but that we are happy to have mandated, that we will continue to improve and continue to rescue money which, I certainly agree, needs to be available to provide care to our elderly and to some of our most vulnerable citizens.

Thank you.

[The prepared statement of Dr. Smits follows:]



STATEMENT OF

HELEN L. SMITS, M.D.

DEPUTY ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES
AND INTERGOVERNMENTAL RELATIONS

HOUSE COMMITTEE ON GOVERNMENT
REFORM AND OVERSIGHT

SEPTEMBER 28, 1995

HCFA
MEDICARE · MEDICAID
Health Care Financing Administration

Mr. Chairman and Members of the Subcommittee:

I am happy to be here today to discuss H.R. 2326, the "Health Care Fraud and Abuse Prevention Act of 1995," as well as to provide updates on the Health Care Financing Administration's (HCFA's) efforts to combat fraud and abuse in the Medicare and Medicaid programs.

HCFA is committed to preventing fraud and abuse in the Medicare and Medicaid programs. However, we must recognize that fraud and abuse is pervasive throughout the health care industry in this country; Medicare and Medicaid are not the only targets. The private sector faces at least as great a problem as the government. As a result, public/private partnerships that bring together the best thinking and the best practices are the key to reducing fraud and abuse. HCFA is continuing its acknowledged leadership in using innovative and aggressive strategies while we work closely with our partners in the private sector and the States.

We also note the leadership role of the Department of Labor through its Pension and Welfare Benefits Administration and Office of Inspector General in combating health care fraud in private employment-based health benefit plans. We urge that, to the extent health care fraud provisions include these private plans, this bill reflects the Department of Labor's important role.

The "Health Care Fraud and Abuse Prevention Act of 1995" speaks to many of HCFA's concerns in combatting fraud and abuse in health care programs. In fact, in a number of areas, the bill reflects activities that HCFA and its Federal partners, the HHS Office of Inspector General and the Department of Justice, are already engaged in. I would like to compliment Mr. Schiff, Mr. Shays, Mr. Towns and their cosponsors for advancing the debate by introducing this bill. Before I begin my comments about the bill, I want to provide you with an update on HCFA's activities in this area.

Since Mr. Vladeck testified before you in June, the Administration has proposed legislation, "The Medicare and Medicaid Program Integrity Act of 1995," to create the Benefit Quality Assurance Program for Medicare and the HHS Fraud and Abuse Control Fund.

Under the Benefit Quality Assurance Program, HCFA would establish specialized, multi-year contracts for program integrity activities. At present, funding for HCFA program integrity activities is subject to the variability of the budget process. This instability makes it difficult for HCFA to invest in innovative strategies to control fraud and abuse. Our contractors also find it difficult to attract, train, and retain qualified professional staff, including auditors and fraud investigators.

The Benefit Quality Assurance Program would provide a level funding stream for a five-year period. This proposal would allow HCFA the flexibility to invest in new and innovative strategies to combat fraud and abuse. It would help HCFA to shift emphasis from post-payment recoveries on fraudulent claims to pre-payment strategies designed to ensure that more claims are paid correctly the first time.

The HHS Fraud and Abuse Control Fund would allow the Department to reinvest savings from settlements and court awards in Medicare and Medicaid fraud cases, after the programs had been made whole, through a fund that can be used to finance further fraud investigations.

Experience has shown that investment in anti-fraud and abuse activities yields a high return. Our proposals would help provide stable funding for these activities and thus help assure that we reap this benefit.

While legislative changes are certainly important, we have made great strides in curbing fraud and abuse under current law. HCFA has pioneered initiatives aimed at prevention, early detection, and coordination. We have financed cutting-edge computer technology through our contractors. We support the development of "state-of-the-art" technology -- increasingly sophisticated information systems -- used by us and our private partners to detect and to deter fraud and abuse.

Focusing on Fraud: The South Florida Workgroup

A successful partnership was created to tackle serious fraud and abuse problems in South Florida. Medicare and Medicaid expenditures in Florida are among the highest in the nation, and fraud and abuse is a serious factor in a variety of health care settings. To address this problem, we established a joint initiative including HCFA, our claims payment contractor, the Florida State Medicaid agency, the HHS Office of the Inspector General, and the Florida Attorney General's Office Medicaid Fraud Control Unit.

The workgroup was formed to provide support and recommendations to HCFA and the Florida contractors about what could and should be done to combat the chronic fraud and abuse in South Florida. The group's effort represented an unprecedented degree of coordination. As a result of its work, we have identified over $100 million in savings and recoupments over five months. HCFA is looking carefully at areas identified as particularly vulnerable to fraud including home health services, durable medical equipment and independent physiological laboratories.

- Because of fraud-related investigations, HCFA suspended payment to 44 South Florida providers since this summer,

preventing the payment of $2.2 million in Medicare funds.

- The U.S. Attorney's office, acting on information detailed by HCFA contractors, has frozen more than $4 million in bank accounts pending further investigation of several providers.

- As a result of our coordinated effort to share information on fraud activities with our contractors, the Florida Medicare contractor conducted intensive medical review of claims for outpatient therapeutic mental health treatment programs. As a result of this review, the contractor denied 77 percent of services billed for 1994. Medicare saved $3 million in Dade and Broward counties alone in 1994.

HCFA has also formed the Program Integrity Group to help identify possible areas of program weaknesses and will help coordinate its activities. The Program Integrity group consists of high level HCFA officials whose expertise will help identify problems in the Medicare and Medicaid provider enrollment process.

This group is currently examining ways of limiting participation of suppliers and providers to those that appear to be legitimate business entities. When considering these options, however, we are conscious of the need to assess the reporting burden and costs that new requirements may pose for honest providers.

Operation Restore Trust

The South Florida workgroup involved an unprecedented degree of cooperation between public and private entities. Based on our successful experience in South Florida, HCFA and the Inspector General have formed a new partnership of Federal and State agencies to crack down on Medicare and Medicaid fraud and abuse. We believe we can accomplish more by working together as partners than we can each achieve alone with the same resources.

This partnership, Operation Restore Trust, is a demonstration targeting five of the most populous states -- New York, Florida, Illinois, Texas and California. These five states account for nearly 40 percent of all Medicare and Medicaid beneficiaries. Our partners include the Office of the Inspector General, the Administration on Aging, the Department of Justice, state government and private sector representatives.

The partnership will identify and penalize those who willingly defraud the government. It will alert the public and industry to known fraud schemes. The partnership will also help identify and correct the vulnerabilities in the Medicare and Medicaid programs. The initiative targets four types of health care providers -- nursing facilities, hospices, home health agencies, and durable medical equipment suppliers.

Tactics include HCFA and IG financial audits; stepping up criminal investigations, civil and administrative penalties, and recovery actions; and increasing surveys and inspections of long-term care facilities in cooperation with State officials. In order to inform beneficiaries, the public and industry, the HHS Inspector General will issue special fraud alerts to notify the public and the health care community about schemes in the provision of home health services, nursing care and medical equipment and supplies. Additionally, a fraud and waste report hotline -- 1-800-HHS-TIPS -- is available for public use.

Operation Restore Trust emphasizes improved communication between Federal and State agencies. In addition, we are demonstrating the use of State quality surveyors to scrutinize possible fraud and abuse by targeted providers. If our experience in South Florida is any indication, this joint effort should yield a substantial savings to the Government.

Under Operation Restore Trust, HCFA has recently opened a satellite office to specifically combat Medicare and Medicaid fraud and abuse. The Miami office will provide assistance to Federal, State and local law enforcement authorities in Medicare and Medicaid investigations. I would like to take this opportunity to share with you some of the results of our Miami office to date.

- A Miami area businessman has been charged with stealing $120 million by submitting fraudulent Medicare claims. His network of bogus companies extended from Miami through Fort Lauderdale. For three and a half years, physicians and beneficiaries were paid to assist in filing false claims. The businessman has agreed to plead guilty and faces up to 15 years in prison for 2 counts of mail fraud and a probation violation.

- 18 defendants have been charged with more than $20 million in fraudulent Medicare claims. This scam involved 5 different providers submitting claims for medical equipment and medications. Providers paid managers of retirement communities for lists of beneficiaries and also bribed physicians to sign prescriptions. The defendants <u>each</u> face up to a 5 year prison term and a fine up to $250,000 and restitution.

The Miami office has also provided assistance to HCFA's Medicare claims processing contractors and the Medicaid State Agency to improve and increase the productivity of their program integrity projects.

- We investigated 200 beneficiaries whose account numbers were used to bill thousands of services in dozens of scams under investigation by HCFA and law enforcement. Beneficiaries

reported that their Medicare cards (containing their Medicare number) were either lost, stolen, or misappropriated.

In response, the Medicare contractor has adjusted its automated claims processing system to reject claims for services to beneficiaries who have received excessive line items of service during the past 30 days. The system is now rejecting about 1,300 claims per day with annualized savings projected at $60 million.

If the claim is rejected, a denial message is printed on the Explanation of Benefits and sent to the beneficiary stating that usage has exceeded normal limits and that documentation of the need for the service must be submitted for an appeal of the denial. To date, no appeals have been received.

- Further adjustments to the automated Medicare claims processing system eliminate payment for certain procedures and establish boundaries on usage for other procedures. These automated reviews have saved an average of $600,000 per month. Annualized savings have been estimated to be $10 million.

- For fiscal year 1995, the Medicare contractor has identified and sought repayment for $12 million in overpayments.

HCFA Is Improving Its Capacity to Prevent Billing Abuse

We are taking a significant step in improving contractor ability to detect billing abuses by installing a new set of edits based on a year long study we have conducted with Administar. These changes will benefit the Medicare Program and its beneficiaries by reducing spending for inappropriately billed services by approximately $300 million per year.

Health Care Fraud and Abuse Prevention Act of 1995

I would like to take this opportunity to comment on specific components of H.R. 2326. Much of the bill would be administered by the Inspector General or the Department of Justice. I will, in general, defer to them on comment pertaining to these sections.

We support the general principle behind the Health Care Fraud and Abuse Control Account, which is similar to the Fraud and Abuse Control Fund proposed by the Administration and contained in H. R. 2280, introduced by Mr. Dingell. We believe such accounts can be very helpful in providing stable funding for fraud and abuse prevention, detection, and investigation.

However, we have concerns about the sources and use of funds in the Control Account, for example, the bill as drafted would include in the Control Account monies collected as civil money penalties (CMPs) that are unrelated to program integrity. These include administrative penalties under Medicare and Medicaid, such as those levied on skilled nursing facilities as intermediate sanctions in place of termination.

These penalties are used to address quality of service issues rather than program integrity and are not related to the activities conducted by the Inspector General or the Department of Justice. Since these penalties are not related to program integrity, we suggest they be excluded from this Account.

We support the permissive exclusion authority in section 301. This authority would alleviate the problem of allowing individuals whose companies have defrauded the Medicare program from obtaining new companies which bill the Medicare program.

The bill's provision relating to inherent reasonableness, section 303, points toward a significant problem with how Medicare now sets the prices it pays for medical equipment and supplies. While we are proceeding with the initiative described in this section, our current inherent reasonableness process, determined by statute, is cumbersome and lengthy and prevents us from responding flexibly to changes in the medical marketplace. In many instances, Medicare is forced to pay prices far in excess of wholesale or even retail prices. Medicare's current payment policies are largely determined by statute, and we endorse giving Medicare statutory authority to set its payment rates for medical equipment and supplies to better reflect the impact of market forces.

We strongly support involving our beneficiaries in combatting fraud and abuse. As we testified in June, we believe beneficiaries are our "eyes and ears," and they provide us with a great many leads about potential abusive or fraudulent situations. Beneficiaries are regularly advised about how they can help combat fraud and abuse through material we send them when we pay a claim. We include this information in the Medicare Handbook, the next edition of which will be sent to all beneficiaries early in 1996. In fact, since we are already actively informing our beneficiaries about fraud and abuse and using them as an important first line of defense, we believe that a statutory mandate is unnecessary.

Regarding the contractor liability provision in section 301, our contractors are already under definite instructions not to pay claims from excluded providers. While we are not aware that there is any significant problem in this area, making contractors liable for such claims, where a pattern of problems is demonstrated, could help insure compliance with these

instructions.

Conclusion

As you can see, there are many areas where we agree. HCFA is committed to working with our partners and the Members of this Subcommittee to confront the challenge of fraud and abuse. As technology changes and our health care system becomes more complex, HCFA continues to ensure access to high-quality, cost effective health care to 70 million of our most vulnerable Americans -- the aged, disabled and citizens with low incomes. Similarly, the Department of Labor continues to ensure that the promise of health coverage, which nearly 100 million workers, as well as their dependents, receive through over 4.5 million employer-sponsored health benefit plans, is kept.

For the past thirty years, HCFA has efficiently paid the health care bills of virtually all senior citizens and today pays for the care of about 20 percent of the nation's children. However, just as medical care improves and changes, so must the Medicare and Medicaid programs.

Taxpayers and Medicare and Medicaid beneficiaries deserve our assurance that each benefit dollar is being spent for needed care and services. HCFA continues to demonstrate the commitment, authority, and leadership to provide this assurance. Through partnerships between government and private industry and sophisticated information technology, we can save Medicaid and Medicare from waste.

Mr. SHAYS. Thank you.

Mr. Stern.

Mr. STERN. Thank you, Mr. Chairman and other members of the subcommittee, for this opportunity to discuss health care fraud enforcement and the two bills pending before this subcommittee.

I think I testified before you before, and at that time informed you that the Attorney General, back in 1993, had named health care fraud as her No. 2 new initiative, right behind violent crime. We created, back in November 1993, an executive level health care fraud policy group, which I chair. The members include the Inspector General of HHS, and now that Judy Berek is on board at HCFA, they attend, as well, our monthly meetings.

We have made a very strengthened, coordinated effort against health care fraud. I think it is beginning to pay off in some of the things you just heard from Dr. Smits.

The bill that you have here today will assist us in one very big way: It will make health care fraud a Federal crime for the first time. We have, up to this date, had to use mail fraud, wire fraud, other hooks, to try to attack health care fraud. I think it is a very strong and important message that you would be giving, that health care fraud, in and of itself, is a Federal crime.

There are other provisions of the bill which I applaud and have done so in our written testimony. In particular, I appreciate the expansion of the criminal antikickback statute to cover the inducement of the referral of business that would be paid for by any Government health care program. At the moment, we are just limited to Medicare or Medicaid.

We appreciate also the administrative subpoena authority for the Department of Justice and the grand jury disclosure provision, which will allow us to share that information, on the civil side as well as on the criminal side, in a much easier fashion.

We do have a few reservations about some provisions of the bill. I have raised those with the staffs already. If I might, I might refer to a few of them right now. There is provision 104(d) of H.R. 2326, which we believe would constitute a severe restriction on the authority of the Attorney General to enforce criminal and civil statutory remedies and would usurp the prosecutorial discretion of the Attorney General.

I would be happy to answer any further questions about that, if you would like to question me on it. The provision itself is in a portion of the bill that relates to the trust fund and is an attempt to limit, I think, the ability to try and use a bounty-hunting method to recover moneys rather than criminal penalties. I applaud that goal, but the way the bill is drafted it would totally interfere, I believe, with the ability of our prosecuting attorneys to settle the cases as the facts provide.

I also have to indicate the Department of Justice is concerned with a provision of Section 210. We applaud your effort to give the Attorney General the right to use subpoena power. In fact, we supported that. The way the bill is written, though, it provides for the Attorney General or the FBI to do that. The way we would prefer that is that the FBI, working through the Attorney General, would do that. That is particularly important.

I think, Mr. Schiff, you might recall from being a U.S. attorney, the desire to at least have some control over a subpoena that somebody in your district would be issuing. The way we would prefer this is, the FBI would talk with the U.S. attorney about the subpoena before it would be issued, because, in many cases, the U.S. attorney will be defending that subpoena when somebody objects to it.

Mr. SHAYS. What section was that? I'm sorry.

Mr. STERN. That is Section 210. The way it now is written, it provides that the Attorney General or the FBI, and we would prefer that it would be just the Attorney General. Also, we would like it to be limited to health care fraud, since that is the purview of the bill itself, and to limit it to the requirement that the person give testimony with respect to the records themselves and not just a more broad-ranging ability to subpoena somebody to give testimony outside of just the records.

Those are the only specific major issues that I would raise with you today. I have discussed a number of more minor and technical issues with your staff. I would be pleased to continue to carry on those discussions with them, if you would like. And I look forward to any questions you might have of us.

Again, thank you very much for having this hearing.

[The prepared statement of Mr. Stern follows:]

Department of Justice

STATEMENT

OF

GERALD M. STERN

SPECIAL COUNSEL, HEALTH CARE FRAUD

DEPARTMENT OF JUSTICE

BEFORE

THE

SUBCOMMITTEE ON HUMAN RESOURCES

AND INTERGOVERNMENTAL AFFAIRS

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

UNITED STATES HOUSE OF REPRESENTATIVES

CONCERNING

H.R.2326

HEALTH CARE FRAUD AND ABUSE PREVENTION ACT OF 1995

AND

H.R.1850

HEALTH FRAUD AND ABUSE ACT OF 1995

PRESENTED ON

SEPTEMBER 28, 1995

Mr. Chairman and other Members of the Subcommittee:

Thank you very much for this opportunity to discuss health care fraud enforcement and two bills pending before the Subcommittee: H.R. 2326, the "Health Care Fraud and Abuse Prevention Act of 1995," and H.R. 1850, the "Health Fraud and Abuse Act of 1995."

Health care fraud imposes an enormous cost to the health care system and to our nation's economy as a whole. Indeed, it may presently account for as much as 10 per cent of all health care expenditures, or as much as $100 billion each year. Health care fraud can also undermine the quality of health care provided to patients, and at the same time increase the cost of care, a price paid by individual consumers, health plans, and American taxpayers.

For these reasons, the Attorney General in 1993 named health care fraud enforcement her number two new initiative, behind violent crime. Since then the Department has had a coordinated health care fraud enforcement program, which involves increased resources, increased investigations and prosecutions, greater cooperation among investigative and regulatory agencies, and coordinated use of all available sanctions -- criminal, civil, and administrative.

From fiscal year 1993 to fiscal year 1994, the Department of Justice, through its coordinated initiative against health care fraud, increased health care fraud convictions from 73 cases to

102 cases and from 96 defendants convicted to 140. Civil judgments and settlements increased from 46 to 60; and the FBI reported that monetary recoveries, including restitution, fines and civil settlements in health care fraud cases increased from $140 million in fiscal year 1993 to in excess of $780 million in fiscal year 1994.

Unfortunately, those who prey on the health care system will continue to do so, in spite of our efforts. The Department of Justice is, however, committed to meeting the challenge of health care fraud with vigorous enforcement. We welcome this Subcommittee's efforts to assist us. H.R. 2326 contains many new statutory "tools" that would greatly assist the investigators and prosecutors in their health care enforcement efforts. The result will be increased savings to the health care industry and substantial savings to consumers, as well. These tools would also help us to operate more efficiently, and, therefore, would save precious law enforcement resources.

Although there are existing federal statutory authorities under which we are able to investigate and prosecute health care fraud, the enactment of a specific federal health care fraud offense, as proposed in section 202 of H.R. 2326, will provide a straightforward vehicle under which to bring such cases. This new statute should eliminate some issues in litigation and, therefore, should result in savings of investigative and prosecutive resources.

The expansion of the criminal anti-kickback statute (section 206 of H.R. 2326) to cover the inducement of the referral of business that is paid for by any government health care program will also have a significant beneficial effect on our enforcement efforts. Our anti-kickback enforcement efforts have confronted significant obstacles because of the limited coverage of the current Medicare/Medicaid anti-kickback statute. Defense counsel routinely argue that the statute does not apply unless the majority or totality of a provider's business is paid for by Medicare/Medicaid. For this reason, kickback prosecutions are vigorously defended and require extensive prosecutorial resources. In addition, because of the limited coverage of the existing statute, many providers are not deterred by it and are unwilling to make restitution for the fraud they commit.

Administrative subpoena authority for the Department of Justice and the grand jury disclosure provision contained in sections 210 and 211 of H.R. 2326 will greatly improve the ability of prosecutors and civil attorneys to share evidence to support criminal and civil health care fraud cases. These tools should eliminate the need for wasteful duplication of effort in pursuing alternative remedies in the health care cases. The resources saved as a result of these, and other provisions in the proposed statute, should be available to investigate and prosecute additional health care fraud cases.

The Department of Justice does, however, have serious reservations about a few of the specific provisions of H.R. 2326.

In particular, the Department does not endorse section 104(d) of H.R. 2326, which would constitute a severe restriction of the authority of the Attorney General to enforce criminal and civil statutory remedies, and would usurp the prosecutorial discretion of the Attorney General. It is appropriate for a prosecutor, in exercising his or her discretion (in determining whether to seek criminal charges, and what charges to seek), to consider the fact that a person is willing to or has repaid the victim of the crime for the losses that the offender caused, and the defendant's remorse and willingness to assume responsibility for his or her conduct. It is also appropriate for a prosecutor to consider many other factors, including litigative risk, and the benefits of the prompt disposition of cases. Section 104(d) of H.R. 2326 could be construed as prohibiting the Attorney General from considering these factors, if any aspect of the case disposition would result in the deposit of funds into the Control Account. Accordingly, the Department of Justice opposes section 104(d) of H.R. 2326.

The Department of Justice also does not endorse the scope of the investigative demand procedures contained in Section 210 of H.R. 2326. That Section would provide that the Attorney General or the Federal Bureau of Investigation could issue administrative subpoenas calling for the production of records, as well as compelling the testimony and attendance of witnesses, in connection with health care fraud investigations or fugitive investigations. We believe that this provision should,

consistent with the intent of H.R. 2326, be limited to health care fraud investigations. Moreover, this authority should be conferred on the Attorney General alone, who could then delegate that authority as she deems appropriate. This will ensure that United States Attorneys across the country, who will be called on to represent the United States in lawsuits challenging the propriety and legality of particular subpoenas, have been given the opportunity to review those subpoenas before they are issued. In addition, we believe that the testimony that is authorized pursuant to this provision should be limited to testimony concerning the production and authentication of the records which are the subject of the administrative subpoena.

As drafted, H.R. 2326 includes within its purview private sector, as well as public sector health plans. We note, in this regard, that the definition of "health care benefit program" in section 202 of the bill appears to be sufficiently broad to include employee health and welfare benefit plans subject to the Employee Retirement Income Security Act (ERISA), which is administered principally by the Pension and Welfare Benefits Administration within the Department of Labor. Because there are approximately 4.5 million ERISA plans, covering nearly 100 million workers with private employment-based health coverage, we believe that the bill should reflect the important role of the Secretary of Labor in health care enforcement. Specifically, we suggest revising the bill to make the Secretary of Labor also responsible, to the extent that ERISA plans will now be covered,

for health care fraud enforcement.

There are other issues about which we have concerns, such as the use of fines and forfeiture proceeds as sources of funds for the Control Account, and the breadth of the authority conferred on four Inspectors General and on state agencies. (See, sections 101(a) and 102(a) of H.R. 2326 and section 2 of H.R. 1850.) We have discussed these concerns and a number of technical amendments with the Subcommittee's staff. We would be pleased to work with you on these issues and on other technical and related amendments. In that connection, we will continue to review these and related legislative proposals and would appreciate the opportunity to apprise you of any additional views that we may have.

Mr. Chairman, this concludes my prepared remarks. Thank you again for the opportunity to appear before you today. I would be pleased to answer any questions that you or the other Members of the Subcommittee may wish to ask.

Mr. SHAYS. Thank you, Mr. Stern. We do appreciate your cooperation. It has been very helpful.

At this time, I would call on Mr. Schiff, if he has any questions, and then we will go to our ranking member.

Mr. SCHIFF. Thank you, Mr. Chairman.

Once again, I want to fully acknowledge that this bill was written with Mr. Shays and his staff and, of course, takes up from what Congressman Towns wrote, and has input from various people in law enforcement and from HCFA.

I would like to ask this question. I would like to ask if any of the panelists have had time to review H.R. 2389, which was filed on September 21? I know that's not immediately the subject of the hearing, but I have the belief that H.R. 2389 is on the fast track to be in the Budget Reconciliation Act, and I just wonder if you have had time to review it. If not, I would understand. It was only filed a few days ago. But may I ask the panelists if you are acquainted with it?

Dr. SMITS. I'm acquainted with it, but "acquainted" is about as far as it goes. We would certainly be glad to submit a commentary for the record. All of these bills appear to be moving very much in the same direction. As you note, there is not conflict. So the question really is the details, and for that I would really like the time.

Mr. SHAYS. Dr. Smits, we do have 7 days, and it would be helpful if you would be able to submit some reaction to it.

Dr. SMITS. We would be pleased to.

[The information referred to follows:]

Dr. Smits.

Many of the provisions of H.R. 2389 are included in H.R. 2425, the "Medicare Preservation Act of 1995". Comments on H.R. 2425 follow.

The Health Care Financing Administration (HCFA) is committed to combatting waste, fraud and abuse in the Medicare and Medicaid programs. HCFA is continuing its acknowledged leadership in using innovative and aggressive strategies while we work closely with our contractors, law enforcement partners and the States. HCFA's role is to prevent and detect fraud and abuse, but it is the HHS Office of Inspector General (OIG) and the Department of Justice (DoJ) that must prosecute and enforce the laws. Thus, federal partnerships that bring together the best thinking and the best practices are the key to reducing fraud and abuse.

Focusing on Fraud: The South Florida Workgroup

A successful partnership was created to tackle serious fraud and abuse problems in South Florida. Medicare and Medicaid expenditures in Florida are among the highest in the nation, and fraud and abuse is a serious factor in a variety of health care settings. To address this problem, we established a joint initiative including HCFA, our claims payment contractor, the Florida State Medicaid agency, the HHS Office of the Inspector General, and the Florida Attorney General's Office Medicaid Fraud Control Unit. The workgroup has identified over $100 million in savings and recoupments over five months.

Operation Restore Trust

The South Florida workgroup involved an unprecedented degree of cooperation between public and private entities. Based on our successful experience in South Florida, HCFA and the Inspector General have formed a new partnership of Federal and State agencies - Operation Restore Trust - to crack down on Medicare and Medicaid fraud and abuse. We believe we can accomplish more by working together as partners than we can each achieve alone with the same resources.

The partnership will identify and penalize those who willingly defraud the government. It will alert the public and industry to known fraud schemes. The partnership will also help identify and correct the vulnerabilities in the Medicare and Medicaid programs. Tactics include stepping up criminal investigations, civil and administrative penalties, and recovery actions. Operation Restore Trust which is currently a five state demonstration project illustrates that collaboration and cooperation provides a multiplier effect. This lesson will be most helpful as we intensify Operation Restore Trust.

The Medicare Preservation Act's Impact on Medicare Fraud and Abuse

Successes of this sort will be much more difficult if the Medicare Preservation Act of 1995 (H.R. 2425) is enacted. Under current law disreputable providers are forbidden from and penalized for engaging in fraudulent and abusive practices. H.R. 2425 seriously erodes some of the OIG and DoJ's ability to pursue and prosecute Medicare fraud and abuse, including most notably: making the civil monetary penalty and anti-kickback laws and physician self-referral provisions considerably more lenient.

The bill would increase the payment safeguard funding levels available to HCFA and hence enable us to pursue our roles of prevention and detection.

Agencies, including HCFA, OIG and DoJ, should have the proper authority and adequate funding to follow up on indications of wrong doing. Crooks will know that the worst that will happen is that they might have to repay HCFA but will not be subject to fines or criminal penalties. This bill reduces the deterrent effects that the current authorities to criminally prosecute and to levy civil monetary penalties have. This will make HCFA's prevention activities less effective.

Taxpayers and Medicare and Medicaid beneficiaries deserve our assurance that each benefit dollar is being spent for needed care and services. Although the bill addresses funding issues for HCFA, it undermines the authority of law enforcement agencies and thus interferes with our ability to combat fraud and abuse.

Mr. SCHIFF. All of the witnesses may.

Mr. STERN. Mr. Schiff, yes, I have reviewed it.

Mr. SCHIFF. How do you view H.R. 2389 in terms of accomplishing what is all of our goal here? Do you feel that it does enough all by itself? Subject to the observations you have made about H.R. 2326, do you think that they could be combined? Do you have any view of that that you would express at this time?

Mr. STERN. We are trying to put together an administration position with respect to H.R. 2389. I think we would be able to submit that at some point within the 7-day period. But, generally speaking, I believe there are some restrictions on our abilities in H.R. 2389 that are very severe, and I am very concerned about some of them.

Specifically, I can recall, off the top of my head, from having read the bill very carefully, restrictions with respect to bringing antikickback cases. Some of our biggest cases in the past 2 years have been antikickback cases: NME, CareMark, together, $379 million in one; $161 million in the other.

H.R. 2389 would put a new burden on the prosecutor, changing the present law, as interpreted by the courts, and would limit our ability to bring these kickback cases. So I am quite concerned about that.

Mr. SCHIFF. Well, since the administration, you believe, will prepare a formal response to H.R. 2389, I would like to respectfully suggest that you look at H.R. 2326 with H.R. 2389 and with the other bills that are there. There are a number, as you well know.

My point is this: One can agree or disagree with individual provisions, but I think from all these bills we might be able to put together a comprehensive and effective antihealth care fraud bill. As I said, it is not important to me whether paragraph one comes from my bill or H.R. 2389; I think we can put it all together. And I am encouraging everyone to work toward that same goal.

On your specific observations, let me say that, on the restriction on plea-negotiating, I want to say I believe you said, Mr. Stern, if I may, that I was a U.S. attorney. I was actually a county district attorney.

Mr. STERN. I apologize.

Mr. SCHIFF. That's all right. Apology is accepted, however. I know, however, your Attorney General has the same background that I did.

Mr. STERN. Yes, she does.

Mr. SCHIFF. In fact, we compared notes and found that we used to tell the same jokes about U.S. attorney's offices. But I suspect the Attorney General is not free to tell those jokes anymore.

Anyway, the point is still the same.

Mr. STERN. I think the issue is the same.

Mr. SCHIFF. Let me acknowledge to you, I believe that that provision should be modified, if it's included in any final bill, to say, "It's the sense of Congress that—" I agree with you that trying to legally get in the middle of a plea negotiation is not an effective way to write legislation.

But I do want to tell you why that provision is there. I have had years to watch the drug models, and what I saw, especially where funds could be used—and I know there's a question about who

should run the trust fund, if there is a trust fund—but when funds are forfeited, what I have seen in enforcement of the narcotics laws is, all too often, the forfeiture got ahead of the goal of a criminal prosecution. And a forfeiture is a good idea, but—Mr. Chairman, may I have 1 more minute?

I ask unanimous consent for 1 more minute.

Mr. SHAYS. You don't have to ask.

Mr. SCHIFF. Thank you, but there are a number of Members here, and I do want to conclude here.

I just want to emphasize this point. What I saw in the drug enforcement model is that, where there was a forfeiture, especially if the forfeiture was used by law enforcement, the forfeiture became the goal over and above the criminal conviction, and that's what I'm objecting to. I'm not objecting to forfeitures.

I've known cases where drugs were being transported in a car that law enforcement agencies wanted that car for future undercover operations, so they dropped the drug charge so that the defendant would agree not to contest the forfeiture of the automobile. Well, the point is, that becomes then a cost of doing business for drug runners. It's no longer a criminal prosecution.

Mr. STERN. Right.

Mr. SCHIFF. And that is a serious issue which I would like to address, but I do agree with you that that provision, at the least, ought to be modified.

Mr. STERN. Thank you very much.

Mr. SCHIFF. Thank you, Mr. Stern.

Mr. Chairman, I yield back.

Mr. SHAYS. I thank the gentleman.

Mr. Towns.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Dr. Smits, in your written testimony, you pointed to Operation Restore Trust as the administration's initiative to coordinate and focus Federal efforts to reduce health care fraud. What is the potential impact of this legislation on Operation Restore Trust? Does it affect it in any way?

Dr. SMITS. I think it strengthens our ability to move forward with the project and with similar projects. As I understand it, it does create—one of our issues, as always, is resources. It does create a fund which would be available to the Inspector General, which could then be made available to us for some of these preventive efforts.

These bills would help us continue to move forward. It mandates our doing some cooperative activities that I think we're doing quite well already, but it helps to have that as a required activity rather than simply something we've initiated. So my sense is, it would move our efforts forward.

Mr. TOWNS. I am concerned about fraud and abuse. As was pointed out earlier, I think we all are. And we recognize that that's something that we need deal with, and in any way that we can save dollars that we need to do that.

However, I'm also concerned about coordination, because that could be another form of abuse, if we don't watch it, in terms of agencies having the responsibility to move forward, in terms of investigation, and not wasting money in that regard, as well, in

terms of all these different agencies investigating the same situation and, of course, using techniques and skills that sometimes can waste our dollars.

Has anyone talked about the coordination of these kinds of efforts?

Dr. SMITS. One of the reasons I described it the way I did, in terms of prevention, early detection, and treatment, is to make clear that HCFA's responsibility is, in a sense, to be the CDC of fraud. We should be brilliant at early detection and at prevention. We are not investigators; we do not develop cases. We learn from our colleagues, because we get better at prevention if they teach us, but we have no desire to take over those activities. We need to continue to work together.

It really is like medicine. If all the attention and all of the resources are on treatment, then we will continue to get the disease; we will all develop the disease. If we really can put some of the resources and some of the attention back to the preventive side, we will all be ahead, because money we don't spend is money we still have for the Government and for the patients who need it.

Mr. TOWNS. I agree with you. I just want to make certain the point is clear that information that you have, that we would make certain that information flows to the various agencies that need that information to be able to help correct whatever the problem might be. That's the thing I'm talking about. I think that, if that happens, I think you're right; I think we can prevent some things from happening. At the same time, I think that, if they do occur, we don't waste resources in terms of dealing with it.

We've had some stories where law enforcement offices have locked up each other, that kind of thing. That's a waste of resources. So we don't want to continue that, because we can't afford the luxury of that. That's the reason I'm saying, make certain that information flows where it should flow so we don't have those kinds of problems.

Dr. SMITS. Feedback is very important. I have staff who say, "Oh, I've referred a whole lot of cases to the Inspector General, and nothing happens." In tracking some of what they have referred, we found there are major cases going forward, and we need to know about that. We need enough feedback to know what information helps and what doesn't. I think that loop is much better now, and I think bills that mandate us to maintain that loop are very important.

Mr. TOWNS. As both of you know, the House and Senate have passed Medicare and Medicaid reform initiatives, intending to cut Federal support for these programs by over $450 billion over 7 years. How would these initiatives impact your current fraud and abuse enforcement efforts, and what is your understanding of how this legislation fits into the reform plans? I ask both of you that.

Dr. SMITS. It's very hard to say, particularly because of the dramatic change in the structure of the Medicaid program. By making the Medicaid program different across States, it would make our cooperation even harder to come by.

I hadn't really thought about the Medicare proposals in that context. I wouldn't see that it specifically makes it more difficult, although I would agree that provisions which help us, particularly

give us enough resources to do good prevention are essential if we're going to continue to move forward in the direction we're already moving in.

Mr. TOWNS. My staff person said I said the floor. Did I say the floor? If I did, I meant out of committee; I didn't mean the floor. It has not passed on the floor. If I said that, I want to be corrected right away.

Dr. SMITS. I'm glad to hear that. That's what I thought, too.

Mr. TOWNS. Mr. Stern, I would like to hear you address that as well.

Mr. STERN. I think, to the extent that the bill that Mr. Schiff referred to, H.R. 2389, which is part of what I think you're talking about, there are some provisions of that bill that are very troublesome for us. As I mentioned, the limitations on our ability to bring antikickback cases, the requirements with respect to advisory opinions that are in that bill, that I think will interfere with our abilities, will help the defendants in ways that are not good for our anti-fraud efforts. There are a number of provisions in that bill that we're quite concerned about.

Mr. TOWNS. Mr. Chairman, will we have another round?

Mr. SHAYS. You definitely will have another round.

Mr. TOWNS. OK. Thank you. I yield.

Mr. SHAYS. I would just like to note for the record we have been joined by Mr. Fox, who will have a statement that we will submit for the record, and any of the other Members who have come, Mr. Green and Mr. Fattah.

I think, Mr. Fattah, you have a competing hearing. Did you want to just say anything before you have to leave?

Mr. FATTAH. Thank you, Mr. Chairman.

I just wanted to note for the record that another one of the standing committees that I sit on is meeting at this time, on the next floor down, and I have to depart. But this is a very important matter, one that not only do I share concerns with the chairman and the ranking member, but my colleague from Pennsylvania and I have spent some time talking about what we can do about health care fraud.

This is not just a matter that relates to governmental programs. It affects the private sector, too. Both have been victims of sustained fraud by people who are committed to finding ways to take dollars out of the health care system. I guess it's somewhat like Jesse James who said he robbed banks because that's where the money is.

Well, the money is in health care now, so we have criminal enterprises that are determined to find ways to get the money out of it. And it is not just the Government that has suffered. We have entities right in my home town, private sector entities, who have been victimized by health care fraud.

So I appreciate your holding these hearings, and I look forward to working with you as we go about trying to figure out what we can do about this. Thank you.

Mr. SHAYS. I thank the gentleman for his help and interest both.

At this time, Mr. Chrysler.

Mr. CHRYSLER. Thank you, Mr. Chairman.

Dr. Smits, what were the lessons learned from the coordinated efforts in the south Florida work group?

Dr. SMITS. I think I've mentioned some of them. The exclusion of problem suppliers. We identified and withheld payment on some clusters of services that appeared to be inappropriate, that were being inappropriately highly used in south Florida, relative to what we saw elsewhere in the country. We benefited greatly from the fact that it's a joint Medicare-Medicaid effort. Our carrier there has excellent data systems.

Mr. Gould is trying to pass me notes, but I think he should comment himself since he's much more directly involved.

Mr. CHRYSLER. Sure.

Mr. SHAYS. Mr. Gould, we are happy to have you participate in this hearing.

Mr. GOULD. One of the major findings is the fact that we have to work together as a coordinated team—I think it's a thing that you've mentioned throughout this hearing today—and not only as Federal agencies, but Federal agencies in concert with State agencies.

One of the major things that occurred in pulling together the task force in south Florida is that we pulled together not only a program task force but also an enforcement task force made up of Federal and State officials. This has to be a unified effort.

People who defraud the system do it on both the Medicare and Medicaid systems, and we need to be able to share information easily between both Federal and State agencies. So I think that's another major piece of the finding from this kind of work and actually became the foundation for the work of Operation Restore Trust.

Mr. CHRYSLER. Mr. Stern, how will the establishment of specific criminal statutes for health care fraud increase the Department of Justice's ability to prevent and deter fraud and abuse?

Mr. STERN. The major point, I think, Mr. Chrysler, is the one I mentioned earlier, that having an actual health care fraud offense, which we do not now have on the books, sends an important, strong message that this is now a Federal crime that we are paying attention to, specifically as a Federal crime, and we do not have to use mail fraud or wire fraud or money laundering or some of the other hooks that we have to use. I think that, in itself, is an important message.

There are specific provisions that I talked about. Expanding the antikickback statute gives us additional tools with respect to Federal health care plans, which are not now covered, other specifics like that. But I think the more important message is the general one that health care fraud is now a Federal offense.

Mr. CHRYSLER. What proposals would the Department of Justice offer in place of section 104(d) to combat the efforts of fraudulent providers to avoid conviction and mandatory exclusion through the plea-bargaining process?

Mr. STERN. Well, I don't have any specific language to deal with that. Mr. Schiff may be as close to resolution of that as I can get. I should point out, though, that I think one of the issues you were concerned about is, if a company pleads guilty, that somehow the company can pay money, plead guilty, and yet stay in the program. The only way we deal with that at the moment is to go after the

individuals who are the ones responsible for doing that at the company.

One of the most important cases recently was the *Bard* case, which was a Fortune 500 company. They pled guilty. They were able to pay a $61 million total payment and stay in the system. But we went ahead with criminal prosecutions of the top six executives of the company and, within the last month, three of them were finally convicted by a jury up in Boston.

These are very difficult cases, but we are not giving up on the individuals, despite the fact that the companies themselves may settle with us.

Mr. SHAYS. Would the gentleman yield just for a second. Just so we have it on the record, what were the convictions of the three? What was their penalty?

Mr. STERN. They have not been sentenced yet.

Mr. SHAYS. OK. Thank you.

Mr. CHRYSLER. Thank you, Mr. Chairman. That's all.

Mr. SHAYS. I thank the gentleman.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. I have a statement I would like to have placed in the record.

Mr. SHAYS. It will be placed in the record.

[The prepared statement of Hon. Gene Green follows:]

Statement of Representative Gene Green
Subcommittee on Human Resources and Intergovernmental Relations
September 28, 1995

Thank you Mr. Chairman for calling this hearing on Medicare fraud and abuse. As a co-sponsor of both H.R. 2326 and H.R. 1850, I am pleased to have this opportunity to discuss these bills in greater detail. The bipartian efforts of last year have served as a starting block for this year's legislation and I would commend my Ranking Member, Mr. Towns of New York and Mr. Schiff of New Mexico for their efforts.

It has been estimated that Medicare/Medicaid fraud and abuse costs the taxpayers up to 10% of our yearly federal health care expenditures. We need to clarify federal jurisdiction over who should investigate and prosecute fraud and follow up more closely to assure that fraudulent providers cannot re-enter the system.

Furthermore, we need to let the public know in clear terms where they should go to report Medicare fraud. I believe these bills take us in that direction and I look forward to the testimony of the witnesses to show us how to make this legislation better.

I thank the Chairman.

Mr. GREEN. I appreciate the opportunity for the hearing today. At our last hearing on this issue, Mr. Vladeck, with the Health Care Financing Administration, had a flow chart on the steps to investigate fraud.

I guess, a lot of Members of Congress, as we talk about Medicare fraud in our districts, there's just a great deal of effort or support from our seniors who want to become active. That chart has helped us be able to talk to not only seniors but also, I found out, particularly in my own family, sometimes it's not the seniors who deal with the hospital bills, it's the children who can catch what no one else may see.

I know we have a toll-free number, and I've publicized that in newsletters and town hall meetings. Like, in Texas, I know it's the responsibility of the contractor. I know the toll-free number. Is that just a Texas number, or is it national? And is there a way we can even do both, contact the contractor in Texas, at the local jurisdiction, but also the national number? Because, again, if we're talking about the estimated $40 billion, we have to use every resource we have.

Dr. SMITS. Well, our contractors do exchange information with each other. So a specific episode should be reported to the local toll-free number. But, yes, those numbers are available nationally.

Those tips are very important to us I think it is helpful to teach people what are the signs. Particularly, services that were not provided is one of our biggest. I mean, errors occur in some bills that are still just errors, but we do need to have people very alert.

I agree with you. Every time I go to New York, I get a pile of EOMBs, and now I'm personally responsible for them since I work for Medicare, but just to explain and go over and help with the problems. And I think teaching everyone how to detect real trouble in those bills is very important.

Mr. GREEN. And I know we try to do it. If you could share with not only our committee but I would hope other Members of Congress anything that we can provide to our own constituents to help them. I know it may be available through local Medicare offices to do that.

Because, again, the double payment or the services that are not provided is probably the biggest complaint or question. Somebody will bring in a bill, in our district offices, and say, you know, "I never saw this physician," or "I don't know who this is," and things like that.

Dr. SMITS. The other thing we need to have people understand is that, when they give us a tip, there are many instances where we are silent because we are working so hard on it. We've had some circumstances where we were very actively—we or someone else was very actively investigating real fraud, and the consumer gets worried because nobody has told them that the tip has been responded to. We need to work some with consumer groups to figure out how to handle that.

Mr. GREEN. Just some kind of saying, "Yes, we're considering it," or something like that.

Dr. SMITS. Right.

Mr. GREEN. What is the most usual way you discover fraud? Is it independent investigators, or is it through the tips that you get or complaints?

Dr. SMITS. I will yield to Mr. Gould on what is the most productive. It is certainly tips from consumers, tips from honest providers who often have an idea that something is going on, the physician who says, "There's something weird about this home care agency." And I'm very pleased that the profession has been working hard on increasing their sophistication about that. And computer-based analysis, which spits out unusual claims and detects unusual patterns.

Mr. GOULD. Also, the work that we've done in terms of creating fraud units in each of the Medicare contractors. That is a real key point in that the contractors now, we work with them to identify key areas that they do look behind, audits, reviews, at the contractor level, along with the work of the IG, the Justice Department, U.S. Attorney. We're looking at this as a full team effort. I mean, every component is important, and we're trying to address it from that point of view.

Mr. GREEN. If you could, I think I would be interested in it, and maybe other Members would be, on that kind of relationship you have that crosses jurisdictional lines, in some cases, to see what we might be able to do to help, and if you have any suggestions, obviously.

Mr. Chairman, with what time I have left, I know we have legislation—and I'm glad Texas is part of the Operation Restore Trust—but is there any redundancy or conflict between H.R. 2326 and also the administration's bill, and how can we address it?

Dr. SMITS. I think we would have to answer that for the record.

Mr. GREEN. OK.

Mr. SHAYS. So that will be followed up in the record.

Mr. Fox.

Mr. FOX. Thank you, Mr. Chairman. I first want to thank you and Mr. Schiff and Mr. Towns for your legislation which moves forward a very important issue. I know that, in my district, seniors and others are very concerned about the fraud, abuse, and waste, and this legislation and the effort of the panel helping us move forward is appreciated.

May I submit my statement for the record?

Mr. SHAYS. It will be submitted for the record.

[The prepared statement of Hon. Jon Fox follows:]

OPENING STATEMENT
CONGRESSMAN JON D. FOX

SUBCOMMITTEE ON HUMAN RESOURCES AND
INTRAGOVERNMENTAL RELATIONS
SEPTEMBER 28, 1995

Mr. Chairman, I thank you for the opportunity to allow me to sit in on this hearing, which focuses on corrective legislation to combat waste, fraud, and abuse in the Medicare and Medicaid programs.

As we take on our heralded effort to reform Medicare and Medicaid, we must first focus on eliminating the current waste, fraud, and abuse that currently exists in this programs. For example, back in my district, I turned to the people of Montgomery County, Pennsylvania to help me formulate positive solutions to the crisis facing Medicare by creating a voluntary Task Force of citizens

representing diverse backgrounds.

The result of their hard work, from holding hearings to critically evaluating documents and written comments, was compiled into this report that I hold in my hand.

Included in this report are positive recommendations to reform Medicare. Their first recommendation focused on the need to combat waste, fraud, and abuse. Concern by the public for abuse by greedy, unscrupulous professionals must be alleviated. Guilty persons must be dealt with harshly. Current set fines are not sufficient because they can easily become merely a cost of doing business. Loopholes in current law that allow fraud abuse to thrive must be permanently closed. Civil monetary

penalties must be placed on the employers of excluded providers who bill Medicare. Lastly, we must take advantage of technological advances to meet the challenges of increasingly sophisticated fraudulent schemes.

In response to these reform needs, my colleagues and I introduced H.R. 2326, "The Health Care Fraud and Abuse Prevention Act of 1995." This hearing is of vital importance in addressing the inherent problems in our health care system. I look forward to hearing from today's witnesses as we explore efforts that are part of a solution to the crisis facing Medicare and Medicaid.

Mr. FOX. Thank you.

Just following up on Congressman Green's point before, is there a welfare fraud hotline number that we should be able to give our constituents? Is there a hotline?

Dr. SMITS. Welfare? You mean health care?

Mr. FOX. I mean health care fraud. Excuse me.

Dr. SMITS. Yes.

Mr. GOULD. It's 1–800–HS–TIPS. That's the national number.

Mr. FOX. OK. So they can call anywhere in the United States.

Mr. GOULD. Anywhere in the United States. And we then screen those calls and then send them back out to the appropriate place.

Mr. SHAYS. If the gentleman would yield.

Tom, I would like you to call that number right now and tell me if it's busy.

Mr. GREEN. Mr. Chairman, if the gentleman would yield?

Mr. FOX. Yes, I would.

Mr. GREEN. We had that problem. And I've asked my constituents—because we have publicized that number—to send us a copy of their complaint, and then we will follow up without having to go through the toll-free number.

Mr. SCHIFF. Would the gentleman yield 1 more second?

Mr. FOX. Yes. I will have to ask for more time.

Mr. SCHIFF. I appreciate that. I cannot say that this is through the 1–800 number, but let me tell you the No. 1 observation that I've received from senior citizens now receiving Medicare on this subject, and that observation is that they noticed some inaccuracy in the billing, that there was some product that they didn't receive or had some other question about it.

And they made a call—and I suspect often that call was to the contractor handling the local regional Medicare system—and basically they were told, "It's too small. Don't worry about it." And I've heard that a number of times. And the impression is that the bureaucracy running the Medicare system doesn't want to be bothered to have to go back and look and correct bills, and so forth. When all that adds up, that can be, obviously, quite a sum of money.

I thank the gentleman for yielding.

Mr. FOX. Following up.

Mr. SHAYS. Excuse me. The gentleman's time is up. [Laughter.]

Mr. FOX. Mr. Chairman, I would ask unanimous consent.

Let me say at this point, panel, let's assume that the line was busy or we wanted to also follow up like my colleague from Texas, what would you recommend to Congressmen and Senators, as far as if we get constituent letters saying, "We know about fraud," what do we do with them?

Dr. SMITS. We're very pleased to receive them in the administrator's office. Send to Mr. Vladeck or myself.

Mr. FOX. At HCFA?

Dr. SMITS. Yes.

Mr. FOX. That's where they should first start, and if the Attorney General is to get involved, you then send the case over.

Dr. SMITS. Yes.

Mr. FOX. Is that the process?

Dr. SMITS. I would like, just for the record, to note, a friend of mine, who is an excellent geriatrician, called not long ago and asked why his carrier was investigating him in such depth. And the answer was that a patient had complained she was billed for services that were never delivered. There was an excellent written record that they had been delivered. She had forgotten. So you have to develop the complaint before you can refer it to the law enforcement officers.

Mr. FOX. Right. But I think many of us here in Congress have gotten those complaints from constituents saying, "I don't know how I got billed for this," that didn't remember receiving the service.

Let me ask you this, if I may, Doctor: What deterrent strategies or tools would HCFA be able to implement with a steady stream of funding, vis-a-vis postpayment recoveries or prepayment strategies?

Dr. SMITS. I think we've heard a lot of them. You need to inform consumers. If, indeed, the fraud hotline was busy, we need to be sure that we have adequate resources to run the line well. You need continued computer development. As I indicated, some of the computer methods that are used by organizations like mutual funds to predict the stock market can be used to find fraud in this vast quantity of claims, but that's expensive.

Mr. FOX. Would it be of any assistance if we offered a reward to seniors for having reported such alleged acts of abuse, and if they are founded, then they receive some kind of economic benefit?

Dr. SMITS. That's an interesting question. You don't want to promise rewards to everyone, because then all the people who forgot that the doctor had come on Thursday will expect money. Perhaps an annual amount of money could be given to the people whose information has led to the most results. There certainly have been instances where some of the very big recoveries that have been mentioned from Justice began with consumers saying, "There's something odd here."

I do think there should be some way to reward them. I'm not sure exactly what that should be, but I think it is a good direction to go in, as long as we're not promising everyone.

Mr. FOX. Right. So some kind of incentive might be good.

Dr. SMITS. Yes.

Mr. FOX. In your view, are current civil and administrative penalties an effective deterrent to waste, fraud, and abuse?

Dr. SMITS. I think I have to refer that to the expert on the panel.

Mr. STERN. Well, first there are administrative penalties that I think Mr. Fox is referring to, and there are also criminal penalties.

Mr. FOX. Right.

Mr. STERN. My feeling is that it's more important that we have the resources and the tools to go after the cases than to work on the penalty side of it. The penalties, I think, are severe enough. Mr. Shays asked earlier about the sentence in the case with respect to the *Bard* folks. We got a recent sentence against Dr. Rutgard in California. After a 5-month trial, he was sentenced by the judge to 11 years in jail, and we repatriated $7.5 million that he had sent overseas.

So we have, on the penalty side, if the judges are willing to give the severe sentences, the ability to get the severe sentences.

Mr. SHAYS. Would the gentleman just yield.

Mr. FOX. Certainly.

Mr. SHAYS. Under what basis, was it mail fraud or wire fraud that you had to get him on?

Mr. STERN. Yes, you have to use mail fraud and wire fraud, either one.

Mr. SHAYS. OK. Thank you.

Mr. FOX. Administratively, would you see any changes besides the criminal penalties?

Mr. STERN. I don't want to speak on HHS.

Dr. SMITS. I think making it easier to exclude. Exclusion is a very powerful penalty.

Mr. FOX. You mean prohibit—you mean, for those who violate, whether it be hospitals or doctors, whatever, insurance companies, that if they have defrauded the U.S. Government then they are never allowed back in?

Dr. SMITS. Right, or they are not allowed back in for 5 years or 10 years.

Mr. FOX. Do you think part of our strategy here, Congress working with the public, there needs to be greater publicity and priority to the problem? I mean, do you think that's part of the solution, making it a public cause? For instance, national public service advertising saying you're a good American if you report this; you're helping to save dollars for health care for those in need if you stop the waste and abuse, and make it something that you hear from every discipline.

Dr. SMITS. People worry about it a lot but feel helpless. Yes, I think some of that might be good.

Mr. FOX. A public ad campaign would not hurt either.

Dr. SMITS. Yes. But I would like to go back to what I mentioned early on, and that is, we need to look at the ownership issue; that is, where a corporation defrauds and where we don't move forward with criminal cases against the individuals, we need to be certain that we can track those individuals so they don't get back into the program in a reconstituted organization with a different name at the top.

Mr. FOX. As Congressman Schiff was saying earlier, that's one of the problems we have. They go State to State. The legislation they have, I think, addresses that.

Dr. SMITS. Right.

Mr. FOX. Thank you very much, Mr. Chairman.

Mr. SCHIFF. If the gentleman would yield just 1 more second.

Mr. FOX. I will yield.

Mr. SCHIFF. I think we have some provisions in H.R. 2326, suggested by your agency, that directly address that issue.

Mr. FOX. Thank you, Mr. Chairman.

Mr. SHAYS. I thank the gentleman. I will call on Mr. Towns in a second, but I'm going to just do my first round of questions.

First, just to clarify something, Mr. Stern, in the sentencing, while the sentencing hasn't been carried out, they have been found guilty, what are the sentencing guidelines? What is the range the judge has to work with?

Mr. STERN. I will have to get you that. As I recall, they were convicted of a number of crimes. So I will have to go and look back now and get that for you. I can do it for the record.

Mr. SHAYS. I would want that for the record. Again, though, you had to go the route of wire or mail fraud.

Mr. STERN. Or false claims.

Mr. SHAYS. Or false claims?

Mr. STERN. Yes.

Mr. SHAYS. Which is a Federal offense?

Mr. STERN. Yes.

Mr. SHAYS. OK. There are number of aspects of this bill that, obviously, I think are important, but I'm coming to the conclusion that one in particular, probably the centerpiece, has got to be making it a Federal crime and giving you the right to pursue this, in terms of theft, embezzlements, false statements, bribery, graft, illegal remunerations, and obstruction of criminal investigation, which is what we put in our bill.

The Medicare bill being brought out by my House Republicans does not include any of that. And it is something we have to work overtime, I think, to get in, because otherwise we're going to continue to have extraordinary fraud, with you having to come in the back door, it seems to me.

My sense is that we are being fairly conservative when we estimate that waste, fraud, and abuse, particularly fraud and abuse, are only 10 percent. I am just hearing so many stories. How would we characterize a doctor who sees 10 patients in the space of 10 minutes, pokes his head in a nursing home, and says, "Louise, how are you doing today?" and then charges us $15 or $20, or more? Would that be fraud, or would that just be abuse?

Dr. SMITS. There obviously is some point at which a visit isn't a visit, and, in fact, there have been instances like that. It's in the grey zone, if you spend a minute. If you only spend a second, it's fraud, but if you spend a minute, perhaps it's abuse. But it doesn't matter, it's inappropriate, and we shouldn't be billed for it.

Mr. SHAYS. Well, it matters only in this sense, though. Would that be criminal? Would you be able to go after someone criminally on that issue?

Mr. STERN. It's a question of intent. And we have cases where it looks, on the face of it—NME is a good example—that the contracts that they had with the doctors were for consulting. In fact, they were sham contracts. No real consulting was going on in connection with the amount of money given. And we have not only got a conviction for NME, but we have convicted some of the people involved in that, one of whom, as I recall, got an 8-year sentence.

So it's a question of the facts in the respective case.

Mr. SHAYS. Again, you didn't have the criminal statutes that we would give you.

Mr. STERN. That's correct.

Mr. SHAYS. Would any of those criminal provisions that we are giving you now enable you—I mean, would "false statements" be how you would go after someone like that?

Mr. STERN. Right now, what we do is, it was always either a mail fraud or wire fraud connection we have to prove.

Mr. SHAYS. OK. But with the statute.

Mr. STERN. With the statute, I would have to prove that, and with the additional comments I made about expanding the antikickback statute so that it goes beyond just Medicare and Medicaid but goes to all Federal plans, the Blue Cross plan for Federal employees here in Washington would now be covered directly, and some of our biggest cases have been the kickback cases. So these are additional weapons.

Mr. SHAYS. Mr. Gould, did you want to respond to that question at all?

Mr. GOULD. It's more on their side.

Mr. SHAYS. OK. Thank you.

Let me ask you, Dr. Smits, in the House bill, on Medicare, it does not really require or encourage HHS to provide expedited readjustment to payment levels, and so on. You basically can take action now, without any legislation that we have.

Dr. SMITS. But it's cumbersome.

Mr. SHAYS. So we need to change the legislation, the point is.

Dr. SMITS. Particularly with certain of our pricing arrangements.

Mr. SHAYS. So it would strike me that that, Mr. Schiff, is something else that we need to weigh in, because that is not included in the legislation.

Mr. SCHIFF. What issue is that?

Mr. SHAYS. This is the whole issue of pricing. HCFA does not have the ability to adjust what it reimburses, so sometimes it is paying well above the market price.

Dr. SMITS. This relates particularly to durable medical equipment.

Mr. SHAYS. When prices go down.

Dr. SMITS. We have book prices, and our authority to reduce those when the market changes or the product changes is very limited.

Mr. SCHIFF. Would the Chair yield for a minute?

I'm familiar with the issue, of course. We've all heard about and we've seen TV programs of "HCFA paid this amount and here's what it sells for." But I wonder if that's a fraud issue versus is that a—are you restricted in purchasing?

Mr. SHAYS. I'm not suggesting that it's a fraud issue. I'm off the criminal issue and I'm on to another provision of our bill, which just is, in the Section 3 area, encouraging HCFA to move forward more quickly. And the question I'm having is, you do need legislation from us?

Dr. SMITS. Yes, in that area. It's an invitation for fraudulent suppliers to come in when they can sell it to us for four or five times what they can sell it to anyone else.

Mr. SCHIFF. If the Chair would yield again, I'm not entirely following why, legislatively, you need changes in order to adjust your purchasing.

Dr. SMITS. Because the mechanism for downward adjustment of the price book on durable medical equipment is extremely cumbersome and regulatory. We need to be allowed to move fast. We need to behave more like private purchasers and take bids.

Mr. SCHIFF. And how you downsize, that book, that's controlled legislatively?

Dr. SMITS. Yes. It's old-fashioned legislation that's based on an assumption that you start with a fair price and you can raise it annually, but nobody thought about giving us rights to lower it.

Mr. SHAYS. In the report that the GAO submitted to us, I think in September of this year, it said, in some cases, it took 995 days to change the pricing mechanism, you know, the actual price of certain products, which is just incredibly an outrage.

Mr. SCHIFF. Most businesses would be out of business if they had that.

Mr. SHAYS. Mr. Towns.

Mr. TOWNS. Yes, if you would yield further.

Mr. SHAYS. Definitely.

Mr. TOWNS. Couldn't this be placed in H.R. 2326?

Mr. SHAYS. It is in our bill. My concern is, it's not in the Medicare bill, the House bill.

Mr. SCHIFF. Does our bill go far enough in addressing it? Does our provision in H.R. 2326 address it enough? Are you familiar with it?

Dr. SMITS. I'm sorry.

Mr. SHAYS. It is in our legislation. It is not in the House Republican effort on Medicare nor is making it a Federal offense. So I'm off the criminal issue; I'm on to what I think is a very significant issue as it relates to how we price these products and how long it takes us to change the price so that we're not giving a generous reimbursement to a product that long since has been reduced in price.

So my only point, to my colleague from New Mexico, is that, again, this is something—and I'm saying it for the record, because I believe that we have got to work overtime to get that into our legislation.

Does the gentleman, Mr. Towns, have a comment?

Mr. TOWNS. No. I agree with you. I think that the antiabuse is very, very important, and I think it can be placed in.

Mr. SHAYS. I'm basically going to go my second round now, Tom, and then I'm going to yield to Mr. Towns.

Dr. SMITS. Mr. Shays, could we submit a response for the record on that. You do have a way for us to downgrade the prices; you don't have competitive bidding, which is something we are very interested in getting in. So perhaps we can work with you.

Mr. TOWNS. That's exactly what I'm talking about.

Dr. SMITS. We can work with you, before the record closes.

Mr. SHAYS. Well, let's just pursue it a little bit more. Do you want to pursue the whole issue of competitive bidding? Is your point, right now, that our legislation will not address that competitive bidding issue?

Dr. SMITS. No. It lets us look at the market better and move faster in reducing. We can move faster, but it doesn't allow us to do things like bidding, which is what the VA does, which is why we are sometimes compared to VA prices. I think we ought to have ways to do competitive bidding. We're a big buyer. Why shouldn't we get the benefit of being a big buyer?

Mr. SCHIFF. If the Chair would yield 1 second.

That's the whole point of our agreeing here that this is not a partisan issue or a pride of authorship issue. If your agency has a sug-

gestion for legislation that would improve how you could function, I think I can speak for the Chair and the other Members, draft something for us and let us have it.

Dr. SMITS. We're delighted to. And we really do appreciate the way we've been able to work with you on this.

[The information referred to follows:]

Section 3 (a) of Mr. Harkin's bill, S. 1193, would give Medicare the authority to use competitive bidding as a means of pricing for durable medical equipment and other items. It would be most expeditious if the Subcommittee would refer to this bill as a source of statutory language that would give Medicare authority to use competitive bidding.

Mr. SHAYS. Let me just say that we need it tomorrow. I mean, I'm being a little facetious.

Mr. SCHIFF. Oh, by the way—yes. Well, if you want to get on the express train.

Mr. SHAYS. If you want to get on the train.

Mr. SCHIFF. That's right. They're going to rush through this station real fast here.

Dr. SMITS. We've seen the express train before. We'll try and get it.

Mr. SHAYS. Let me just say, the Medicare bill, in deference to criticisms by Republicans, and particularly Democrats, that this is too much of an express train, we had a meeting yesterday with our leadership, and this bill is not coming out of the Ways and Means Committee this week or next week. It will be available to the public and to my colleagues for over a week. So we need to take a quick look at that bill.

I can say, I have been in more than a number of meetings with the Speaker, and he said, "Listen, any suggestions to improve this bill, we should jump at the opportunity." So I'm grateful that my colleagues made enough noise and enough of us on our side have responded to it so it will be, in fact, available for over a week before it goes out of committee. And then it goes to the full House, and we have time, and then there's conference, and so on. The sooner the better you can get it to us.

Given that I've gone on here, Mr. Towns, I'm going to give you some time to follow up with some questions.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Mr. Stern, as you noted, Section 202 of H.R. 2326 may be interpreted or read to include the Department of Labor's Employee Retirement Income Security Act, ERISA, plans in its definition of a health care benefit program. You suggest that the bill should include the Secretary of Labor in its health care enforcement provision, given the bill's coverage of ERISA plans.

Would it be simpler to exempt the ERISA plan from coverage? In the event that monetary penalties are imposed, should ERISA plan assets be deposited into the health care fraud and abuse control account?

Mr. STERN. My problem, Mr. Towns, is that this is the Secretary of Labor's area, ERISA, and I talked with them yesterday about this, trying to understand their concern, which is why we have that provision in my prepared testimony. I don't know that it would be simpler to exempt ERISA if every other health care plan is going to be involved in this overall health care fraud and abuse program.

So I wouldn't want to try and take one particular part out if everybody else is going to be in.

I do think that this is not our money.

Mr. TOWNS. That's the point.

Mr. STERN. Well, that's the point with respect to whether the money should go into the control account. I do agree with you that you can't take somebody else's money and put it into the control account. But whether or not the fraud and abuse control authorities that were being given to attack health care fraud should cover ERISA, as well as other health care plans, I think they should.

Mr. TOWNS. We want to try to, wherever there are problems and conflict, we want to make certain that we work them out. I think that the atmosphere and climate is just terrific in the fact that we all are committed to the same goal and that we want to sort of get there, and try to make the strongest possible bill.

Mr. Stern, the Justice Department does not support Section 104(d) of H.R. 2326, which prohibits the Government from reducing jail time in exchange for payment. What do you understand to be the goal of this provision? Does the HHS IG share your concerns?

Mr. STERN. I actually have not talked to the IG about that particular provision. I understood the goal to be what we discussed earlier, that you don't want to have somebody able to plead guilty and get off with payment of money and then just go right back into the program.

Mr. TOWNS. Let me rephrase that. I understand what you're saying, and I'm very sensitive to that issue. But how might this goal otherwise be accomplished? That's what I'm really saying. How can we do this?

Mr. STERN. We are trying to do it now by making certain that we prosecute the individuals. Even though the company itself may plead guilty and make a payment, you still are trying to go after the individuals. So that's one issue.

As a separate issue, with respect to the company itself, whether the company should be able to plead guilty and still stay in the plan, and that is a question with respect to the exercise of the authority of the HHS, when it comes to excluding somebody from the Medicare program, there we have to be very careful that we do not make—"we," that is, as a joint group, HHS and the Justice Department—a tradeoff.

Clearly, the Justice Department view is, we do not tradeoff. We do not, in our negotiations, do any negotiating with respect to exclusion. That is supposed to be left to the agency. All we're supposed to be doing is the criminal and civil side.

So I think there are two different issues here, Mr. Towns. I hope I haven't confused them with you. But I think the way the language was written, it ended up causing a bigger problem, that is, by prohibiting the prosecutor from even negotiating a settlement with an individual, where there might be criminal or civil penalties. And that's what I was talking to Mr. Schiff about earlier.

Mr. TOWNS. One last question, Mr. Chairman.

Mr. SHAYS. That's fine.

Mr. TOWNS. Mr. Stern, do you believe it is possible that the expansion of the authority of the DOD, Labor, OPM, and Veterans'

inspectors will affect their efforts to go after fraud in their own programs? I'm concerned about spreading ourselves too thin here.

Mr. STERN. It could. It could, and we have expressed a concern about that with the staff. Particularly, there is an example in the bill where the State folks might be given the authority to go in and investigate Federal crimes. I think there is enough State health care fraud so that we don't have to add an additional authority to them to go after Federal crimes.

We discussed this with the staff, in terms of sort of a pending jurisdiction theory. If somebody is working on health care fraud and it slops over into an area outside of their jurisdiction, I certainly think they should be able to continue to work on it. But to say to them, you now have wide-ranging authority to go after any particular health care fraud, whether it's your program or not, whether it's your State or not, I think does dilute their efforts.

Mr. TOWNS. Last—this is a very quick answer.

Mr. SHAYS. It's a quick question with a long answer.

Mr. TOWNS. It's a quick question and a quick answer, too.

The south Florida experiment seems to be working quite well. Law enforcement authorities, everybody seems to be very pleased with the sharing of information and the effectiveness of the program, which you demonstrated here this morning in terms of this information that's coming forward.

Is there any real thought to move this forward in other areas where there appears to be a high concentration of fraud? I understand there are areas in the country where it seems to be quite prevalent. Is this kind of effort being thought about, or is it so expensive that you can't do it? Could you just answer that very quickly?

Dr. SMITS. Operation Restore Trust moves it forward into four other areas where lots of Medicare beneficiaries reside. But, in the long run, our ability to do this kind of thing well depends, in part, on resources, and that's why we believe there should be some form of a trust fund that we can draw on, so that we can afford to have the money to do the detection.

Mr. TOWNS. Thank you.

I yield back, Mr. Chairman. Thank you very much.

Mr. SHAYS. I thank the gentleman.

We have another panel with three witnesses. I notice that our colleague, Bill Martini from New Jersey, is here, and he is welcome to make a comment or ask questions. If he wants time to gather his thoughts, do either Mr. Schiff or Mr. Fox have any other follow-up questions before?

Mr. SCHIFF. Not a follow-up question, but one more quick observation.

Mr. SHAYS. Sure.

Mr. SCHIFF. And that is, I want to emphasize the importance of an antihealth care fraud fund. Now, there is some disagreement about who should manage that fund. But the fund itself I think is important for this reason: The agencies which investigate and prosecute health care fraud are appropriated agencies, and they are facing, at best, a freeze on their funding. But under everybody's plan, the entitlement programs will still go up, like Medicare.

My point is, if you freeze those who are investigating fraud while you spend more money on fraud, you're inviting a disaster, because the people out there know that there will be fewer people to patrol for more money. That's why we have to take some action to bolster the resources of those who are investigating and prosecuting fraud.

Mr. FOX. Mr. Chairman.

Mr. SHAYS. The gentleman, Mr. Fox.

Mr. FOX. Thank you, Mr. Chairman.

Dr. Smits, just to follow up on the telephone, I know that the call got through, which was good, and the chairman was, I think, very timely to ask us to check it.

Mr. SHAYS. With that in mind, I'm going to ask the gentleman to yield.

If counsel would just explain exactly what happened.

Mr. HALLORAN. All right, if I may. Our clerk called the number, got an electronic menu of choices of what he was calling about, Medicare-Medicaid fraud, Social Security, Head Start, Public Health Service, FDA, Crime by an HHS employee, welfare or food stamps, to write to the Department, to get a fax, or an OIG publication.

He chose menu item No. 1, Medicare-Medicaid fraud, and was taken to another electronic menu that said, "Are you calling about nursing homes in New York, Florida, Texas, or California, Medicare-Medicaid provider? Are you a Medicare beneficiary? Calling about Medicaid, general fraud questions, or fax or address?"

He chose No. 4, Medicaid, off the menu, and got a tape that said call a Government phone number, call HCFA at another 800 number, or wait for the address to write with your tip. He went back to the main menu and identified himself as a Medicare beneficiary and got a similar tape. And went back to the main menu, identified himself as a provider, and got a person to speak to about what he was calling about.

[The HHS OIG supplemental statement follows:]

Supplemental Statement for the Record

HHS Office of Inspector General

Background Information on OIG Hotline

The U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) hotline was instituted in 1979 to facilitate the reporting of allegations of fraud, waste, and abuse in Department's programs. In examining the experiences of the past 16 years of hotline operations, the OIG found that a majority of callers were seeking information, and a much smaller number of callers were reporting incidents of suspected fraud. This trend has continued as shown by statistics from June though September of this year, when a monthly average of 2,620 inquiries have been received with 770 of these being referred for further review. Statistics are not yet available for the number of calls currently being received, however, in Fiscal Year 1994 there were more than 93,000 calls to the hotline.

In early 1995, with the inception of Operation Restore Trust, Inspector General June Gibbs Brown requested a review of hotline operations with the goal of providing enhanced services and capabilities. To accomplish this, a contract was let to design a state-of-the-art hotline that would attempt to meet the many demands placed on it for service. Based on the recommendations made by the consultants, an action plan consisting of three major components was developed. In furtherance of this plan another contractor was hired, a new telephone system installed, and an enhanced computer tracking system developed, all with the goal of enhancing the ability to report, detect and prevent fraud.

Due to the limited Federal staff resources available, the first component involved selecting a contractor to staff the hotline, enabling the OIG to provide a flexible response to the variable demands placed upon the system. The contractor selected brought many years of government experience in OIG efforts to combat fraud and waste. Using the contract as the vehicle, we were able to shift resources to meet peak demands for service.

Also, a new toll-free hotline number, 1-800-HHS-TIPS, was implemented to give people an easily remembered method for contacting the hotline to report fraud. In addition to its existing Post Office box and to keep pace with the advances of technology, a toll-free FAX line was also installed giving people an additional option of transmitting information to the hotline.

The second component in the OIG effort to provide the best possible service to the widest spectrum of callers in the most efficient manner was the selection of the FTS2000 AT&T InfoWorks data base platform. This computerized menu driven system is intended to direct calls to the appropriate entity for dealing with the most commonly asked questions or complaints. InfoWorks has the ability to answer up to 400 calls simultaneously, thereby limiting the cost of personnel resources, and virtually eliminating frustrating busy signals experienced by callers in the past. The scripting for InfoWorks is based on more than 16 years of experience managing the HHS hotline. The majority of calls that are received do not involve actual instances of fraud, but rather procedural or technical questions. The InfoWorks menu system directs calls that have a high probability of fraud to an operator by means of term recognition. We are thereby able to provide appropriate service to the majority of people calling our hotline, while preserving our limited staff resources for those callers who are reporting actual instances of fraud.

In the specific instances of Medicare or Medicaid fraud, a case is usually initiated by contacting the Medicare carrier or intermediary. The carrier or intermediary fraud unit, funded for this purpose by the Health Care Financing Administration, develops the facts and, when appropriate, refers the case to the OIG for further investigation and potential referral for prosecution. Most matters handled by the units do not reach the fraud threshold, and are dealt with administratively.

The last component in the OIG effort to prevent fraud was the enhancement of a computerized hotline tracking system to effectively track information received and ensure that all allegations of fraud are brought to a successful conclusion. This system records all pertinent information both for tracking individual complaints and statistical reporting.

This integrated approach has enabled the OIG to operate a state of the art hotline to handle the increasing volume of calls effectively and efficiently. Beneficiaries, providers, employees, and the public in general benefit from this OIG effort to reach out for assistance in combating fraud, waste and abuse in HHS programs. The hotline has become a team effort between HHS and its clients, the American people, to ensure a sound future for government efforts to help those who truly need help, and to punish those who would abuse the trust the system is based upon.

Mr. FOX. That leads up to my question, if I may.

Mr. SHAYS. OK.

Mr. FOX. Thank you. We had a little tandem here.

Having spoken to the staffer myself, it seems as though, and I think that Larry well explained, it's more user-friendly for providers to report abuse than it is for claimants or subscribers or seniors. So I guess one of the things we might want to look into is making it easier for seniors to be able to speak to a real, live person at some point.

Dr. SMITS. The Inspector General, as you gather just from the nature of the menu, runs that number. Since they weren't here today, it isn't fair to answer for them. But I do think we need to talk about whether it belongs collected with all these other things, and particularly about the clear distinction between providers and beneficiaries. But why don't we leave the record open for them to respond on that.

Mr. SHAYS. Yes. That's fine.

Mr. FOX. May I just ask one follow-up question?

For my purposes, in Pennsylvania, is there a HCFA regional office they can write to, or do they write to Washington, DC?

Dr. SMITS. They can write to the HCFA regional office. They can write to their carriers or intermediaries.

[The address follows:]

Health Care Financing Administration
Philadelphia Regional Office
3535 Market Street
Room 3100
Philadelphia, PA 19104

Mr. FOX. Is the regional office in Philadelphia?

Dr. SMITS. Yes.

Mr. FOX. Yes.

Dr. SMITS. I can give you the address for the record.

Mr. FOX. Thank you very much.

Thank you, Mr. Chairman.

Mr. SHAYS. Mr. Martini.

Mr. MARTINI. Yes. Thank you, Mr. Chairman. My apologies, Mr. Chairman, for not being here and having the benefit of listening to the testimony on this important subject. I compliment you and the members of this committee for holding this hearing.

I would just like to add to the comments that I will ask you for unanimous consent to submit to the record, just very briefly, that over the summer, having held many town hall meetings, many with seniors, the one area that seemed to be almost unanimous consent by the seniors was the need to have better mechanisms to enforce weeding out some of the excesses that exist in our Government medical providers' systems.

So this is an important hearing, and this is very important legislation. I have had the benefit of going through some of it, and we have offered an amendment on part of that, which, I understand, you are aware of. But I just want to compliment you again for holding this hearing and thank the witnesses for coming here today and enlightening us on some of the areas that, hopefully, we can remedy.

[The prepared statement of Hon. William J. Martini follows:]

HEARING ON H.R. 2326
HEALTH CARE FRAUD AND ABUSE PREVENTION ACT
SUBCOMMITTEE ON HUMAN RESOURCES
STATEMENT AND QUESTIONS PREPARED FOR
CONGRESSMAN BILL MARTINI
SEPTEMBER 28, 1995

THANK YOU MR. CHAIRMAN. I WANT TO JOIN IN CONGRATULATING YOU, CONGRESSMAN SCHIFF, AND RANKING MINORITY MEMBER MR. TOWNS FOR THE EXCELLENT JOB YOU HAVE DONE CRAFTING THIS IMPORTANT PIECE OF LEGISLATION.

I HAVE SAID IT BEFORE AND I WILL SAY IT AGAIN, THEIR SHOULD BE ZERO TOLERANCE OF WASTE, FRAUD AND ABUSE IN FEDERALLY FUNDED PROGRAMS.

THE MEDICARE AND MEDICAID PROGRAMS PROVIDE MANY ESSENTIAL SERVICES TO MILLIONS OF AMERICANS. HOWEVER, AS WE HAVE HEARD FROM THE INSPECTOR GENERAL AND MANY OTHERS BEFORE THIS SUBCOMMITTEE, THESE PROGRAMS MAY BE DEFRAUDING THE AMERICAN TAXPAYER OUT OF SOME $24 BILLION A YEAR.

OVER THE PAST FEW MONTHS, I HAVE CONTINUALLY RAISED CONCERNS ABOUT ONE PROGRAM IN PARTICULAR, THE NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) PROGRAM.

TO REFRESH YOUR MEMORY, THIS PROGRAM PROVIDES TAXPAYER FUNDED TAXI SERVICE TO MEDICAID RECIPIENTS.

SOME UNSCRUPULOUS INDIVIDUALS ARE TAKING ADVANTAGE OF THE PROGRAM BY RECIEVING FREE TRANSPORTATION TO SUCH PLACES AS THE MALL OR ANYWHERE ELSE THEY CHOOSE BECAUSE OF THE LACK OF ACCOUNTABILITY IN THE SYSTEM.

TAXICAB COMPANIES IN FLORIDA AND OTHER STATES HAVE BEEN GETTING RICH OFF THIS FEDERAL PROGRAM.

ONE COMPANY IN PALM BEACH COUNTY, FLORIDA BILLED THE GOVERNMENT FOR OVER $4 MILLION LAST YEAR ALONE.

IN RESPONSE TO THIS SITUATION CONGRESSMAN RICHARD BAKER, CONGRESSWOMAN TILLIE FOWLER AND I HAVE WORKED WITH THE NON-EMERGENCY MEDICAL TRANSPORTATION PROVIDERS ON A COMPROMISE AMENDMENT THAT WILL CLEAN-UP THIS PROGRAM.

INITIALLY, MY COLLEAGUE FROM LOUISIANA INTRODUCED LEGISLATION IN THE LAST CONGRESS THAT WOULD HAVE ABOLISHED THE NEMT PROGRAM ALTOGETHER.

A NUMBER OF FLORIDA NEWSPAPERS HAVE PRINTED ARTICLES HIGHLIGHTING THE ABUSE IN THE NEMT PROGRAM.

I HAVE ON SEVERAL OCCASIONS NOTIFIED HCFA AND SECRETARY SHALALA THROUGH THIS SUBCOMMITTEE ABOUT PROBLEMS WITH NEMT.

YET, NOTHING HAS BEEN DONE TO CORRECT THE SITUATION. THE ABUSE CONTINUES, AND TAXPAYERS ARE LITERALLY BEING TAKEN FOR A RIDE.

IT IS TIME FOR CONGRESS AND SPECIFICALLY THIS COMMITTEE TO ACT.

OUR PROPOSAL IS SIMPLE, STRAIGHTFORWARD, AND QUITE FRANKLY, IT'S THE RIGHT THING TO DO.

THE MARTINI AMENDMENT WOULD ENSURE THAT ONLY INDIVIDUALS WHO ARE BLIND, SEVERALLY DISABLED, OR MEDICALLY INCAPACITATED WILL BE ELIGIBLE FOR NON-EMERGENCY TRANSPORTATION SERVICES UNDER MEDICAID.

SECONDLY, THE REQUEST FOR TRANSPORTATION MUST BE INITIATED BY THE DOCTOR'S OFFICE RATHER THAN BY THE PATIENT.

FINALLY, THE TRANSPORTATION PROVIDER MUST HAVE AT LEAST ONE PERSON WITH BASIC MEDICAL TRAINING IN THE VEHICLE.

I WOULD LIKE TO COMMEND THE NATIONAL MEDICAL TRANSPORTATION ASSOCIATION FOR ITS LEADERSHIP ROLE IN OUR EFFORT TO REFORM THE NEMT PROGRAM.

MR. CHAIRMAN AT THIS TIME I WOULD LIKE TO SUBMIT FOR THE RECORD, A COPY OF MY AMENDMENT AND A COPY OF A LETTER OF SUPPORT FROM THE NATIONAL MEDICAL TRANSPORTATION ASSOCIATION. IN ADDITION, I WOULD LIKE TO SUBMIT A STATEMENT ON BEHALF OF CONGRESSMAN BAKER FOR THE RECORD.

I LOOK FORWARD TO WORKING WITH THE CHAIRMAN AND THE RANKING MINORITY MEMBER ON THIS IMPORTANT INITIATIVE IN AN EFFORT TO ROOT OUR WASTE, FRAUD AND ABUSE IN THE MEDICAID SYSTEM. A SYSTEM THAT IS VITAL TO THE AMERICAN PEOPLE.

QUESTIONS:

1. AS YOU CAN GUESS, I WOULD LIKE TO KNOW YOUR FEELINGS ABOUT THE NEMT PROGRAM AND SPECIFICALLY THE MARTINI AMENDMENT?

2. AM CONCERNED ABOUT REPORTS WHICH REVEAL THAT WASTE, FRAUD, AND ABUSE IN THE MEDICARE AND MEDICAID PROGRAMS MAY COST THE AMERICAN TAXPAYER OVER $24 BILLION ANNUALLY. MY QUESTION IS ARE THESE ESTIMATE TRUE AND WILL H.R. 2326 HELP TO CURB THE RAMPANT ABUSE THAT PLAGUES THE CURRENT SYSTEM?

NMTA

National Medical Transportation Association, Inc.

September 27, 1995

Subcommittee on Human Resources and Intergovernmental Affairs
House Government Reform and Oversight Committee
Washington DC 20515

Dear Mr. Chairman,

The National Medical Transportation Association supports the Martini Amendment to HR 2326 to eliminate waste and abuse in the Medicaid program and to ensure that medically necessary nonemergency medical transportation services are provided to individuals who are disabled and in need of mobility assistance.

The National Medical Transportation Association represents private-for-profit operators who provide door-through-door medically necessary nonemergency medical transportation for the stretcher bound, wheelchair bound, developmentally disabled, and the disabled and elderly who need assistance in ambulating.

Sincerely yours,

Larry Lynch

Larry Lynch
Executive Director

P.O. Box 296 • San Bruno, California 94066 • (415) 877-8250 • FAX (415) 952-9989

AMENDMENT TO H.R. 2326

OFFERED BY MR. MARTINI

Page 47, insert after line 17 the following (and redesignate the succeeding provisions accordingly):

(c) IMPOSITION OF CIVIL MONETARY PENALTY ON BILLING FOR CERTAIN NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES UNDER MEDICAID.—Section 1128A(a)(1) of the Social Security Act (42 U.S.C. 1320a–7a(a)(1)), as amended by subsection (b), is amended—

(1) by striking "or" at the end of subparagraph (D);

(2) by adding "or" at the end of subparagraph (E); and

(3) by adding at the end the following new subparagraph:

"(F) is for a nonemergency medical transportation service provided to an enrollee of a State plan under title XIX if the provider of the service knows or should know that—

"(i) the enrollee to whom the service is provided is not blind, severely disabled, or medically incapacitated (in accordance with guidelines established by the Secretary, except that an individual may not be treated as severely disabled or medically

incapacitated under such guidelines solely on the basis that the individual is an alcoholic or is addicted to drugs),

"(ii) the service is not provided to transport the enrollee to or from an individual or entity providing medical assistance to the enrollee, and the request for the service is not initiated by such individual or entity, and

"(iii) during the time the service is provided, at least one individual with first aid or other medical training does not accompany the enrollee.".

Mr. SHAYS. I thank the gentleman.

If there are no further questions, you have been wonderful witnesses.

Mr. TOWNS. Mr. Chairman, I really appreciate this, I want you to know.

Mr. SHAYS. This is an important issue, and we love your knowledge and your input.

Mr. TOWNS. Dr. Smits, you talked about the trust fund, and I think that that's very important and a very important fund, but it's my understanding that H.R. 2326 would not include you.

Dr. SMITS. But it would include the Department. We are one department. The Inspector General would be permitted to pass funds to us for our program.

Mr. TOWNS. And the Attorney General. You're talking about the Inspector General and the Attorney General. I think that's what it says it would go to now. But you are on the front line.

Dr. SMITS. I'm not sure I want to ask the Attorney General to pass it across departments. The HHS Inspector General should be able to provide it to us, to the program, for detection and prevention. But perhaps you would like to include some language that encourages them to do that, at least.

Mr. TOWNS. OK. Fine. Mr. Chairman, let the record reflect.

Mr. SHAYS. May the record reflect.

Again, I thank all three of you for coming and testifying.

Dr. SMITS. Thank you very much.

Mr. STERN. Thank you.

Mr. SHAYS. If we could call on our next and last panel, and if they would remain standing: Lovola Burgess, Bill Mahon, and Tom Schatz, if you would all three come forward.

[Witnesses sworn.]

Mr. SHAYS. For the record, I would like to note that all three witnesses have responded in the affirmative.

In deference to New Mexico, Ms. Burgess, you will go first.

Ms. BURGESS. Thank you.

Mr. SHAYS. Nice to have you here. For the record, we have stated where you are from and your areas of expertise. Nice to have you here, and we welcome your testimony.

Mr. SCHIFF. Just before the testimony, may I have just 1 minute of personal privilege?

Mr. SHAYS. You may have as many 1-minutes as you want.

Mr. SCHIFF. I will only take one. You are very accommodating. I appreciate it.

I just want to mention that Ms. Burgess is the immediate past president of the national American Association of Retired Persons and is a constituent of mine. We have had numerous discussions about numerous issues. At times, we don't always agree, but we've always had very mutually enlightening conversations.

And especially what I appreciate about Ms. Burgess is the fact that she emphasizes that the issues are not generational issues, that every generation has to keep in mind that this links to every other generation, and all work for common goals and not to try to pit senior citizens versus school children or get into any of that kind of warfare, which I've always appreciated.

Thank you very much for that.

Mr. SHAYS. I thank the gentleman.

We look forward to your testimony. Why do I smile when I look at your face?

Ms. BURGESS. I want you to know that Congressman Schiff and I quite often disagree, but I want you to know, too, that I always vote for him. [Laughter.]

Mr. SHAYS. Well, you know what, you take the words out of—why don't you continue.

STATEMENTS OF LOVOLA BURGESS, PAST PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS; WILLIAM J. MAHON, EXECUTIVE DIRECTOR, NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION; AND THOMAS A. SCHATZ, PRESIDENT, CITIZENS AGAINST GOVERNMENT WASTE

Ms. BURGESS. I am Lovola Burgess, the immediate past president of the American Association of Retired Persons, and I am still on the board of directors. I appreciate very much the opportunity to be here before you today.

You certainly have all heard the stories of unscrupulous providers who double-bill, who provide unnecessary services or no services at all. And we have also all read about the providers who bill the Medicare program for gourmet popcorn and limo services. Clearly, we do have a problem.

Not only are limited health care dollars lost, but such activities also increase costs throughout the entire system. Consumers pay more out of pocket and are at a higher risk of personal injury when care is not provided as needed or when inappropriate services or items are furnished. In addition, unscrupulous providers find it easiest, I think, to prey on the elderly often the sickest and most vulnerable in the population.

We believe that many providers could be prevented from abusing the Medicare program if they were limited to only one provider number, requirements for obtaining a provider number were toughened, and claims auditing practices were strengthened, also if there were adequate resources for fighting fraud and abuse.

Having the right enforcement tools and enough financial means to investigate and prosecute fraudulent providers are essential if we are to save money and reduce fraud and abuse. Such authority, though, must be weighed carefully against an individual's right to confidentiality of personally identifiable medical information.

AARP is pleased that H.R. 2326 would increase criminal and civil monetary penalties, establish a health care fraud and abuse data base accessible to the public—and we think that's important—and require use of a single provider number in the submission of claims. All of these actions should help to reduce the financial burden fraudulent and abusive activities place on Medicare as well as on other health insurance programs.

In addition, creating a new criminal code provision that specifically addresses health care fraud, establishing a fraud and abuse control program, and creating a fraud and abuse control account are all measures established by H.R. 2326 that should significantly assist authorities in investigating and prosecuting fraudulent providers.

AARP believes, however, that the financial resources available through the new control account should be in addition to current discretionary spending that is appropriated specifically to fight fraud and abuse, and that this account should not be a replacement for such funding.

We are pleased that H.R. 2326 recognizes that consumers and employees can also be helpful in fighting fraud and abuse. Requiring that an annual notice be sent to Medicare beneficiaries outlining the need to prevent and report instances of fraud and abuse against the Medicare program, and implementing a new rewards program is, I feel, a very good start.

The best solution, we believe, would be to develop a comprehensive preemptive Federal privacy law that applies to all settings where personally identifiable health information is collected, stored, used, or released. Such legislation should precede or be enacted concurrently with legislation dealing with health care fraud and abuse.

I would also like to comment briefly on the Republican House leadership's proposal to curb fraud and abuse. Specifically, it would increase beneficiary outreach efforts, provide for higher criminal and civil monetary penalties, and create an anti-fraud and abuse task force, as well as an anti-fraud and abuse trust fund.

However, AARP believes the proposal does not go far enough. In particular, the leadership's proposal lacks the requirement for a single provider number, a critical element, we believe. Also lacking is any provision to amend the U.S. Code to include a criminal code provision that specifically addresses health care fraud. AARP is also very concerned that the leadership's proposal weakens the physician's self-referral laws, laws that minimize provider fraud and abuse.

In conclusion, it is important to note that while fraud and abuse prevention and deterrence activities will most likely generate some savings, improved enforcement will necessitate an added up-front cost. This whole issue is a litmus test for Government effectiveness and stewardship. Please do consider it.

Mr. Chairman, thank you for this opportunity to testify.

[The prepared statement of Ms. Burgess follows:]

Bringing lifetimes of experience and leadership to serve all generations.

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

H.R. 2326:
THE HEALTH CARE FRAUD AND ABUSE
PREVENTION ACT OF 1995

Presented by

LOVOLA BURGESS
AARP Immediate Past President
and
Member, Board of Directors

before the

Human Resources and Intergovernmental Relations Subcommitee
of the
Government Reform and Oversight Committee

of the

United States House of Representatives

WASHINGTON, D.C.

September 28, 1995

For further information contact:
Michele Kimball or Tricia Smith
Federal Affairs Department
(202) 434-3772

Good Morning. I am Lovola Burgess from Albuquerque, New Mexico. I am the Immediate Past President of the American Association of Retired Persons (AARP) and a Member of the Board of Directors. I appreciate the opportunity to appear before the Subcommittee today to discuss H.R. 2326, the Health Care Fraud and Abuse Prevention Act of 1995, and the fraud and abuse provisions included in the Republican House Leadership's Medicare proposal.

Mr. Chairman, the American public views government's ability to address the growing problem of fraud and abuse in our health care system -- particularly in the Medicare and Medicaid programs -- as a litmus test for government effectiveness and stewardship. Showing the American public that we take the issue of fraud and abuse seriously and are taking aggressive actions to curb the problem is necessary before they will be willing to consider tougher actions to limit Medicare spending and reduce the deficit.

The Problem

The General Accounting Office (GAO) has estimated that fraudulent and abusive activities represent as much as 10% of expenditures in our total health care system. This could mean as much as $100 billion will be lost to fraudulent providers in 1995. In the Medicare program alone, this could represent as much as $18 billion. In fact, no one really knows exactly how much is lost to fraud and abuse -- it could be more, it could be less.

We've all heard the stories of unscrupulous providers bilking the Medicare and Medicaid programs, as well as private insurers, out of hundreds of thousands, even millions of dollars. We've heard of the providers who double bill, provide unnecessary services or no services at all, yet bill the insurance programs anyway. We know about the sham operations set up specifically to defraud insurance programs, deceiving vulnerable beneficiaries into revealing their policy numbers. And we've all read about the providers who've billed the Medicare program for gourmet popcorn and limo services.

Clearly, there is a problem. Not only are limited health care dollars lost to fraudulent and abusive providers, but such activities increase costs throughout the entire health care system. Costs are increased for private and public insurance payers, and for consumers as well. Consumers pay more out-of-pocket and are at a higher risk of personal injury when care is not provided as needed or when inappropriate services or items are furnished. In addition, unscrupulous providers find it easiest to prey on the elderly -- often the sickest and most vulnerable population.

Recommendations

Fighting fraud and abuse is not new to Medicare or other federal health care programs, but reported incidents of fraud and abuse are growing rapidly and outweighing enforcement authorities' current ability to curb the problem. AARP believes that public health care programs should be equipped with significant prevention and deterrence

mechanisms. Moreover, it is essential that enforcement authorities be provided with adequate resources to investigate and prosecute fraudulent and abusive activities.

Single Provider Number. Many unscrupulous providers could be prevented from abusing the Medicare program if they were limited to only one provider number and if the requirements for obtaining a provider number were strengthened. Today, it is simply too easy to obtain not just one, but several provider numbers. Often abusive providers who have been caught inappropriately billing under one number will continue billing under another number. In addition, some who have been convicted of defrauding the Medicare program in one jurisdiction will merely pick up and move to another area, applying and obtaining a new provider number without being discovered.

Enhanced Claims Auditing. Simply put, it is too easy to defraud and abuse the system and get away with it. For instance, many providers who participate in the Medicare and Medicaid programs know that the chance of their claims being audited is relatively small. The Health and Human Services Department has indicated that, on average, only 3 out of every 1,000 claims are audited for miscodings and inconsistencies. AARP believes auditing practices can and should be strengthened. Knowing that their claims are being audited carefully may deter some unscrupulous providers from even attempting to defraud the Medicare program. It is our understanding that commercially available software can analyze millions of possible code combinations. In fact, the General

Accounting Office has indicated that the use of such a system could yield significant program savings in the first 5 years of implementation.

Adequate Enforcement Resources. Adequate resources for fighting fraud and abuse are equally as important as prevention and deterrence mechanisms. Having the right enforcement tools and enough financial means to investigate and prosecute fraudulent and abusive activities are essential if we are to save money and curb the instances of health care fraud and abuse.

Privacy Safeguards. Providing officials with the right enforcement tools -- such as subpoena authority -- is important in the fight against health care fraud and abuse. However, such authority must be weighed carefully against an individual's right to confidentiality of personally identifiable medical information. AARP believes that safeguards to maintain an individual's privacy with regard to personal medical records must be established prior to or concurrently with health care fraud and abuse legislation.

Identifying Appropriate Care. AARP also believes that more emphasis should be placed on providing the most appropriate care for an individual as one way in which to make the entire health care system more efficient. Resources should be made available to help identify what procedures and services are most appropriate and provide the best outcome when treating a particular illness. For example, can a medication work just as well as a surgical procedure in some instances? If so, an unnecessary and costly treatment can be

avoided. While reducing the incidence of fraud and abuse should save money, far more resources are expended on inappropriate or unnecessary care. Building a quality, affordable health care system for the future will require heightened emphasis in this area.

To this end, AARP welcomes the opportunity to comment on the legislation introduced by Chairman Shays and Representative Steven Schiff -- H.R. 2326, the Health Care Fraud and Abuse Prevention Act of 1995, and on the fraud and abuse provisions in the House Leadership's Medicare proposal.

H.R. 2326 - The Health Care Fraud and Abuse Prevention Act of 1995

AARP is pleased that H.R. 2326 would increase criminal and civil monetary penalties, establish a health care fraud and abuse data base accessible to the public as well as to enforcement officials, and require use of a single provider number in the submission of claims. All of these actions should help to reduce the burden fraudulent and abusive activities place on Medicare, as well as on other health insurance programs.

Creating a new criminal code provision that specifically addresses health care fraud, establishing a health care fraud and abuse control program, and creating a health care fraud and abuse control account are all measures that should significantly assist authorities in investigating and prosecuting fraudulent providers. At present, this job is difficult at best because of a lack of adequate enforcement tools and financial resources. H.R. 2326 would provide a much needed boost to these anti-fraud and abuse efforts. It is

important to note, however, that AARP believes that the financial resources available through the new control account should be in addition to current discretionary spending appropriated specifically to fight fraud and abuse, and that this account should not be a replacement for such funding.

As you are aware, many of the cases of fraud and abuse are brought to the attention of authorities by the direct involvement of consumers or employees of unscrupulous providers. It is, therefore, important to encourage their involvement in rooting out fraud and abuse. Requiring that an annual notice be sent to Medicare beneficiaries outlining the need to prevent and report instances of fraud and abuse against the Medicare program is a good start. In addition, a carefully implemented rewards program for information leading to the prosecution and conviction of fraudulent providers could act as an incentive for citizens to get involved who otherwise might not.

One area about which we are very concerned is maintaining the confidentiality of personally identifiable medical information. Medical records can contain very sensitive personal information. We recognize that fraud investigations and prosecutions frequently require reviewing medical records without the individual's consent and in some cases making private medical information part of a public record. It is essential, therefore, that there be a meaningful process for balancing public need for this information against potential damage to an individual patient, and for imposing limits and safeguards when a disclosure is found to be justified. Whether present federal criminal procedure is

adequate to the task is a question that should be seriously examined before moving ahead with this legislation.

The best solution, we believe, would be to develop a comprehensive, pre-emptive federal privacy law that applies to all settings where personally identifiable health information is collected, stored, used or released. This would include such areas as fraud prevention, electronic payment systems, electronic medical records, and the creation or maintenance of hard copy or electronic databases containing personal health information. Such legislation should precede or be enacted concurrently with legislation dealing with health care system fraud and abuse.

Fraud and Abuse Provisions in the House Leadership's Medicare Proposal

The Republican House Leadership's proposal to curb fraud and abuse would increase beneficiary outreach efforts, provide for higher criminal and civil monetary penalties, and create an anti-fraud and abuse task force, as well as an anti-fraud and abuse trust fund. Though these are all necessary steps in fighting fraud and abuse, AARP believes the proposal does not go far enough.

In particular, the Leadership's proposal lacks the requirement for a single provider number, a provision that could go a long way toward preventing fraud and abuse. Also lacking is any provision to amend the U.S. Code to include a criminal code provision that

specifically addresses health care fraud. Such a provision would greatly assist law enforcement authorities in prosecuting unscrupulous providers.

AARP is deeply concerned that the Leadership's proposal weakens the physician self-referral laws. Doing so could increase unnecessary services and may cause physicians to make decisions about the choice of provider that may not always reflect the patient's best medical interest. Almost inevitably, health care costs will increase for both the beneficiary and the Medicare system.

Finally, as previously discussed with regard to H.R. 2326, we are concerned with the lack of adequate privacy safeguards for individual medical records. In addition, AARP believes that a carefully implemented rewards program could act as an incentive for those to get involved who otherwise might not. However, the Leadership's proposal should clarify that rewards would be forthcoming for information leading to prosecution and conviction of fraudulent activities.

Conclusion

Mr. Chairman, I appreciate the opportunity to appear before the Subcommittee today to discuss the important issue of fraud and abuse in our health care system. It is important to note, however, that fraud and abuse prevention and deterrence activities will most likely generate only limited savings, and that improved enforcement will add up-front costs. Left unaddressed, fraud and abuse within the health care system will have a

Mr. SHAYS. Thank you. You are obviously a real pro.

Mr. Mahon. We welcome your testimony.

Mr. MAHON. Thank you, Mr. Chairman. It's nice to see you all again this morning, and we appreciate your continued interest in our comments on your legislative efforts.

NHCAA, as I mentioned in our June testimony, is a private-public cooperative organization that combines the anti-fraud activities of private payers with the activities of Federal and State law enforcement agencies who have jurisdiction over the problem. As such, Mr. Chairman, our comments don't represent the comments of any one of those public agencies or of any one of our member companies; rather, they are intended to be a general set of comments on the legislative efforts to date.

I want to commend you and Mr. Schiff and Mr. Towns for two principal things: one is taking the all-payer approach that you have embraced in the course of analyzing the problem and deciding how to address it. That is critical to an effective approach to health care fraud, because, in fact, the majority of dollars spent in the United States on health care are private-sector dollars.

To the extent that anti-fraud efforts limit themselves to Medicare, Medicaid, or Government-program fraud, the likely result will be a fraud-shifting, similar to cost-shifting, in which the providers realize that now it's more dangerous to defraud Government programs, so they are not going to go out of the fraud business, they are going to turn up the heat against private payers.

The second principal point that we are delighted to see you make is to address fraud in a free-standing, bipartisan manner. I think there is a real danger, with things moving so rapidly with respect to Medicare and Medicaid, that something will, in fact, rush through that falls far short of a well-rounded approach to health care fraud.

We have always felt that this is an issue that lends itself to strong action in and of itself and does not have to be tied to broader and perhaps more controversial or divisive health care issues. So I think you are very much on the right track in that respect.

Mr. Chairman, I will just briefly summarize some of the comments we made specific to the legislation. I was asked to comment both on H.R. 1850 and H.R. 2326. By its nature, H.R. 1850 is not intended to be an all-payer approach, but it does have a couple of key points that we think can be refined in H.R. 2326 as H.R. 1850 is incorporated therein.

One is the provision for data-sharing, not only among Federal law enforcement agencies, but among private insurers. I think the bill also says health care providers and health care insurers, but at least insurers are critical to involve in any data-sharing loop.

Both H.R. 1850 and its incorporation in H.R. 2326 also make clear that civil penalties and damages to be deposited in the trust fund are to be funds other than restitution. That is a key point from the private payers' perspective, in that restitution is an issue that you often don't find on the radar screen in the course of criminal cases that private payers have referred to law enforcement. The private payers, obviously have a very real and compelling interest in some reasonable assurance of recovering the funds that they lose to some of these ongoing frauds.

With respect to H.R. 2326 and the all-payer approach, you have done admirable work in providing some of the very essential ingredients of such an approach. One is the creation of the Federal crime of health care fraud and the related crimes of false statements, obstruction of criminal investigations of health care fraud, and so forth.

In the real world, those will make it easier for prosecutors to indict cases. They will make it easier to explain the crime to juries. And, in a very far-reaching way, they also take into account the fact that the system is moving away from paper claims, in its entirety, over the foreseeable future. Someday mail fraud may be a thing of the past on which to rest a health care fraud case. So the idea of a broad health care fraud crime is very useful, not only to public programs but to private payers.

Some of the legal tools that you provide to Government investigators and prosecutors will have a benefit to private payers to the extent that Government agents employ them in the course of pursuing private sector fraud cases: the administrative subpoenas, the exchange of grand jury information, the ability to bring injunctions, and so forth.

So I think you are doing a commendable job of reaching for a well-rounded approach. The other thing I need to cite in that regard is your extension of the antikickback illegalities not only to other Government programs, but to dealings involving any health care benefit plan. That is an essential aspect of creating a balance between the public and private sectors' ability to go after health care fraud, and that should have some very strong merit from the private payer side.

There are two things I would cite, Mr. Chairman, that represent, to me, ideal inclusions in any all-payer bill. One is the provision of immunity from civil liability, not simply for reporting final adverse actions to a new data base or for reporting suspected fraud to law enforcement, but for sharing investigative information between insurer and insurer. That's a critical way in which fraud schemes are detected much earlier in their life spans and through which insurers can bring stronger cases to law enforcement.

Mr. SHAYS. If you would just yield a second.

Mr. MAHON. Sure.

Mr. SHAYS. Are insurance companies prevented now from sharing that information?

Mr. MAHON. They are not prevented by antitrust laws, and State laws generally tend to recognize the need for that sort of insurer-to-insurer exchange. But because so many of the fraud cases today are multistate in nature or nationwide in scope, it's hard to rest your hopes on any one State statute for protection in that regard.

What we have suggested is that it would be much more useful, in the context of all of the current law enforcement initiatives and requests of private payers, to establish a uniform Federal standard of immunity from civil liability, so long as information is shared in good faith and without malice, and so long as patient-privacy considerations are taken into account.

Mr. SHAYS. Thank you.

Mr. MAHON. The second would be the provision of a simple and clean Federal civil cause of action for private payers related to the

crime of health care fraud itself. You have incorporated a civil cause of action for any victim who is victimized by the illegal remunerations violations, but one of the key principles in an all-payer approach is not to expect the government to do the private side's work, in its entirety, for it, but to better equip the private payers to go after the problem.

To the extent that private payers were given a simple Federal civil cause of action, that would create another avenue through which they could take effective action without directly relying on law enforcement resources.

As we said in June, one of the upshots of this all-payer approach is that the better equipped the private payers are to investigate and prosecute and obtain recoveries, the more the government is going to realize a reciprocal benefit, because, in most cases, the provider who is defrauding Medicare, Medicaid, CHAMPUS, and the like, is defrauding Blue Cross-Blue Shield of Tennessee, Aetna, Employers Health, and vice versa.

So you've got the Government taking a strong approach on one hand, and if the private payers are better equipped to do the same, then both are going to realize the benefits of each other's anti-fraud efforts.

I will close with that, Mr. Chairman, but again I will thank you and Mr. Schiff and Mr. Towns for your consistent attention and your commitment to doing something. I think you are very much on the right track.

Thank you.

[The prepared statement of Mr. Mahon follows:]

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Testimony of

William J. Mahon
Executive Director

National Health Care
Anti-Fraud Association

before the

Subcommittee on Human Resources
and
Intergovernmental Relations

of the

Committee on Government Reform and Oversight

United States House of Representatives

Thursday, September 28, 1995

Mr. Chairman, Members of the Subcommittee.

The National Health Care Anti-Fraud Association appreciates the invitation to appear before you again today and to comment on H.R. 2326—the "Health Care Fraud and Abuse Prevention Act of 1995"—and on H.R. 1850, the "Health Care Fraud and Abuse Act."

As we noted in the Subcommittee's June 15, 1995 hearing, NHCAA is a 10-year-old private-public non-profit organization that combines the anti-fraud operations of private-sector health care payers with those of the public-sector agencies responsible for investigating and prosecuting health care fraud.

Our mission is to improve the private and public sectors' detection, investigation, civil and criminal prosecution, and ultimately, prevention of health care fraud [See **APPENDIX I**, *Fact Sheet*].

As before, Mr. Chairman, NHCAA's comments today are intended to reflect only a general private-payer perspective—i.e., we are not representing the point of view of any public-sector agency or of any individual private-sector organization.

AN "ALL-PAYER" APPROACH IS ESSENTIAL TO FIGHTING ANY HEALTH CARE FRAUD EFFECTIVELY

In NHCAA's June 15 testimony, we urged the Subcommittee to consider that the most effective way to protect the public interest in addressing fraud against the nation's health care payment systems is through a so-called "all-payer" approach, recognizing (1) that the public impact of health care fraud extends far beyond its effect on the Medicare, Medicaid and other government programs and (2) that any effective new anti-fraud effort must be tailored to certain realities of the crime, specifically:

- that private-sector health care expenditures exceed those of government health-insurance programs, representing 57 % and 43 %, respectively, of the nation's total health care outlay;
- that in most cases, dishonest providers who defraud government programs also defraud private health insurers, and vice-versa;
- that the typical health care fraud scheme is aimed at multiple private and public payers simultaneously; and
- that any deficiencies in current law notwithstanding, it already is far more dangerous for dishonest providers to defraud Medicare and Medicaid than to steal from private payers.

In that context, we noted, any legislative effort that focuses solely on increasing enforcement activities and the legal penalties related to fraud against government health insurance programs—without addressing the private-sector side of the fraud equation—is likely to result in a "fraud-shifting" analogous to the familiar cost-shifting phenomenon. That is, rather than risk even more severe penalties by defrauding the government, dishonest providers will follow the safer path of intensifying their fraudulent-billing activity against private payers.

With that in mind, Mr. Chairman, it is very gratifying to see elements of that all-payer approach reflected in both H.R. 2326 and H.R. 1850, and we commend you, Mr. Schiff and Mr. Towns for having taken the initiative to address health care fraud in a well-rounded, and thus more effective, way.

We must emphasize here that advocacy of an all-payer approach does not suggest that government must also assume all responsibility for investigating and prosecuting fraud against private health insurers. That would be unrealistic and impractical. On the contrary, one principal purpose of an all-payer approach is to better equip private payers to pursue *their own* anti-fraud efforts more effectively—with a resulting reciprocal benefit to the government's enforcement efforts.

It is in that context that we respect and appreciate the legislative efforts you have made thus far and that we will comment on how those efforts might be refined so as to be optimally effective. We certainly hope that you will receive these comments in the spirit in which we offer them—i.e., as constructive suggestions for the Subcommittee's consideration.

ESSENTIAL INGREDIENTS OF AN EFFECTIVE ALL-PAYER APPROACH

NHCAA has long cited several elements that it considers central to improving private payers' effectiveness in fighting fraud, namely:

1. The establishment of a uniform federal standard of immunity from civil liability (e.g., defamation, libel, invasion of privacy, malicious prosecution) for health insurers' good-faith reporting of suspected fraud—not only to the appropriate law-enforcement authorities, but equally important, to other insurers, who might well be targets of the same fraud scheme.

Given the nature of most false-billing frauds, the practical need for good-faith insurer-to-insurer exchange of investigative information on suspected fraud is well recognized in many state laws, the more recent of which are explicit in their protection of such information-sharing activity. However, state laws vary widely, and in the face of today's multi-state or nationwide fraud schemes, the value of any one state law is at best limited.

The bottom line: To detect many fraud schemes earlier in their lifespans, and thus stem the flow of fraud losses earlier, it is essential that private payers' investigative units be able to exchange information with the expectation of a reasonable and uniform standard of legal protection for doing so without malice. Furthermore, as federal authorities increasingly call on private payers to act more aggressively by referring more actions for criminal prosecution, the situation demands a reduction of the legal risk that companies often run in doing so.

2. The establishment of a federal civil cause of action for private payers who are targets of health care fraud.

Currently, the government enjoys—and has employed very successfully— the legal strength of the federal civil False Claims Act in bringing health care fraud actions. Private payers, however, lack a comparable civil legal tool at the federal level.

In dealing with multi-state or nationwide frauds, private payers can file (and have filed) civil suit under the provisions of the Racketeer-Influenced Corrupt Organization Act, or RICO. However, RICO actions are far more complex to pursue than would be a simple private right of civil action at the federal level. The establishment of such a right of action is an excellent example of enhancing private payers' ability to take effective action against frauds that might well also be victimizing government programs.

3. The assurance of a reasonable expectation of restitution in cases referred for criminal prosecution. All too often, the matter of restitution to private payers is not given adequate consideration in the course of criminal cases involving those payers. This issue takes on even more significance if one assumes (a) that those payers will increasingly be called upon to refer more and more such cases to law enforcement and (b) that law enforcement itself will face increasing demands to "self-fund" its enforcement activities through some form of depository account for fraud recoveries.

To that list of essential ingredients, we would also add:

- the need to make illegal against private-sector health plans what is currently illegal only against Medicare and Medicaid—i.e., kickbacks for patient referrals and the routine waiver of patient co-payments when used as a marketing "hook" for fraudulent-billing schemes—after appropriate exceptions are made for above-board financial arrangements that are inherent in various types of managed-care systems; and

- the practical need for newly coordinated federal and state law-enforcement efforts to involve private payers.

With these principal points in mind, we offer the following comments on H.R. 2326 and H.R. 1850.

H.R. 1850

As H.R. 1850 has been substantially incorporated in H.R. 2326, some comments herein will apply to both bills.

Standing on its own, H.R. 1850 by its nature does not address most of the essential ingredients cited in the preceding section.

At the federal level, it limits the coordination of law-enforcement activities to those of the various Inspectors General cited in the bill. Although it would empower those I.G.'s to act against fraud and abuse "in violation of any federal law," from a practical standpoint, the scope of those agencies' efforts would be limited to cases involving their respective programs.

By contrast, the addition in H.R. 2326 of the Attorney General to that list of Inspectors General reflects a practical—and essential—jurisdiction over private-payer cases.

At the state level, H.R. 1850 would grant to state health care fraud units similar jurisdiction over fraud and abuse "in violation of any federal law in the state." Absent a specific health care fraud violation (as contained in H.R. 2326), those state units would theoretically be able to prosecute private-payer cases under the federal mail-fraud statute. However, because both bills' descriptions of those state units make them appear congruent to the Medicaid Fraud Control Units that exist in most states, the intent of this provision of both bills is unclear.

If the intent is in fact to broaden the MFCUs' jurisdiction to include private-sector cases, it raises questions regarding the overlap of such jurisdiction with (1) increased federal efforts and (2) the increasing number of state insurance fraud bureaus with similar jurisdictions. It also raises resource-allocation questions that are beyond the scope of private payers and more within the purview of the Inspector General of the Department of Health and Human Services.

H.R. 1850 does reflect one essential ingredient not contained in H.R. 2326. That is on page 9, subsection (d) entitled "Data-Sharing, which would provide for the sharing "of data related to possible health care fraud" not only among federal, state and local law enforcement agencies, but also among "health care providers and insurers." Although we would question the inclusion of "health care providers" in that list, the inclusion of health insurers is central to any effective data-sharing program.

With respect to another essential ingredient, it is gratifying to see that in their specification of deposits to the Health Care Fraud and Abuse Control Account, H.R. 1850 and H.R. 2326 both stipulate that deposits from civil penalties and damages shall be funds "*other than restitution.*" As noted, that is an important principle, and one that we hope the Subcommittee would consider applying more broadly with respect to "proceeds of seizures and forfeitures of property."

From the private payers' standpoint, the potential problem inherent in establishing such a self-funding mechanism for law-enforcement efforts is that it effectively places law enforcement and private-sector victims in a competition of sorts for the assets available in any given case. Thus it is essential to incorporate adequate restitution provisions up front.

H.R. 2326

H.R. 2326 contains several measures that can benefit private payers directly and others that can have a beneficial, if indirect, impact on private-sector cases. All of these measures are contained in Title II, "Revisions to Criminal Law."

Most notable from the private perspective are:

(1) the creation of the federal crimes of health care fraud and "false statements relating to health care matters" and the establishment of strong penalties for their commission;

(2) the application of "illegal remunerations" illegality to all-payer dealings, and the establishment of a private civil cause of action for victims of such schemes.

Also of indirect benefit to private payers, to the extent that law enforcement employs them in the course of private-payer cases, are the bill's enhanced law-enforcement tools, specifically:

(1) the establishment of the crime of obstruction of criminal investigations of health care offenses;

(2) the ability to obtain injunctive relief to bring ongoing fraud schemes to a halt;

(3) the availability of "authorized investigative demand procedures," or administrative subpoenas; and

(3) the ability of criminal prosecutors to share grand-jury information with their civil counterparts.

Collectively, the establishment of these new violations and the provision of better law-enforcement tools can have both a beneficial impact on actual cases and a deterrent impact on potential fraud perpetrators.

Absent from H.R. 2326, however, are two points that would significantly enhance private payers' fraud-fighting ability and effectiveness:

(1) the aforementioned private civil cause of action for the crime of health care fraud itself. This would give private payers an efficient legal tool comparable to the government's False Claims Act and would represent a channel through which they could combat fraud without a direct reliance on law enforcement resources; and

(2) the establishment in federal law of immunity from civil liability for insurers' good-faith reporting of suspected fraud and sharing of investigative information.

H.R. 2326 establishes such immunity for the reporting of information to a new federal database of final adverse actions (for which immunity is somewhat superfluous, in that those actions constitute public-record information) as well as for replies to administrative subpoenas, but it fails to address the area in which such good-faith immunity is most needed: active investigations of suspected fraud.

Again, such a concept is not new; it merely represents the application at the federal level of what so many state laws recognize as an essential ingredient of fighting fraud effectively.

One example of such federal application has appeared in a draft health care fraud bill recently assembled by Representative Tom Coburn of Oklahoma, himself a practicing physician. In the course of providing for the provision of data by health insurers to the HHS Secretary and to the Attorney General, the Coburn draft included the following language:

> (iii) Qualified immunity for providing information.—The provisions of Section 1157 (a) of the Social Security Act (relating to limitation of liability) shall apply (i) to a person providing information or communications to the Commission, the Secretary or the Attorney General in conjunction with the performance of their duties under this Act *or (ii) to health plans sharing information in good faith and without malice with any other health plan with respect to matters relating to health care fraud detection, investigation and prosecution* [emphasis added].

The inclusion of such a provision in any new anti-fraud measure would go a long way toward removing what is both a real and perceived liability risk that often discourages private payers from acting against given frauds.

Also absent, but essential to a cohesive effort, is any provision for the coordination of law enforcement efforts and the sharing of data with private payers—a feature of virtually every "all-payer" proposal offered in Congress in recent years. From a practical standpoint, law enforcement will have to rely on private-payer input in identifying, investigating and successfully prosecuting health care fraud on a broader scale

Beyond that, Mr. Chairman, we would offer one perfecting note with respect to the proposed federal database of final adverse actions against health care providers. Among the "information to be reported" regarding a given action should be the Taxpayer Identification Number, or absent that, the Social Security Number of the subject of the action. The inclusion of that identifying information—particularly the Taxpayer I.D. number—is essential to private payers' efficient use of such a database, in that it is the primary basis on which they would readily identify their claims exposure to any provider reported to the database.

Again, Mr. Chairman, thank you for the opportunity to comment on these proposals, and for your and the Subcommittee's dedication to developing a practical and effective approach to health care fraud.

We hope that our comments are helpful to that effort, and we will be happy to continue to work with the Members and staff in its furtherance.

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Mr. SHAYS. I thank the gentleman.

Tom, I sometimes call you Schatz or Schatz, which is it?

Mr. SCHATZ. Schatz.

Mr. SHAYS. OK. I won. For the record, I get the last word.

Mr. SCHATZ. Thank you, Mr. Chairman. I appreciate being here.

Mr. SHAYS. Thank you.

Mr. SCHATZ. I, too, will certainly echo the support of this legislation and the wonderful cooperation, the bipartisan cooperation, on this issue that is being displayed by this committee today. Given the vitriolic nature of some of the debate over Medicare, it's nice to find an area where we can pretty much agree that things need to be done and we can agree on how it needs to be done.

I will take just a few minutes, Mr. Chairman, to mention a report the Citizens Against Government Waste issued, that I would like to submit for the record, which is called, "Medicare Fraud: Tales from the Gypped." The report chronicles 89 examples of waste, fraud, and abuse, and the information uncovered by the report and our research shows that the problems of fraud in Medicare are indicative of the problems of fraud in health care, in general.

As you know, Mr. Chairman, on Medicare itself, we do need to have reform. We are all aware that the trust fund will be out of money in the year 2002, and, in particular, in Medicare, action needs to be taken quickly.

The Inspector General of HHS, June Gibbs Brown, has stated that fraud and abuse permeates all aspects of Medicare, that up to $17 billion, or $46 million per day, 10 percent of Medicare's budget, will be wasted because of fraud, and that ties with other estimates of health care fraud, in general. I agree with you, Mr. Chairman, that 10 percent is a very, very conservative estimate. We have heard from some of the people over at HHS, it could be as high as 30 percent.

From that standpoint, if you are talking $17 billion in Medicare or up to $50 billion in Medicare, it's a very serious issue, and it should be the first thing in the Republican leadership's legislation, not necessarily something that you are chasing the train with. We have been trying to emphasize that, and we are happy that there is certainly an effort in the leadership bill to deal with health care fraud and abuse. I think we have learned today that some improvements could be made.

Mr. SHAYS. If the gentleman would just suspend for a second.

I would encourage all three of you to weigh in with any of the leadership that you have contact with—particularly, AARP has been in close contact, as your organization has. To pass this legislation hoping to get at fraud without having it be a criminal offense and all-payer, as you point out, Mr. Mahon, it just would be very unfortunate. I am concerned that we have a ways to catch up to this group. So I hope that you would get your organizations to do that.

Mr. SCHATZ. Well, in fact, Mr. Chairman, we are in the process, and letters have just hit our membership to ask them to write to the President, urging him to make sure that the fraud and abuse is dealt with in Medicare reform.

Mr. SHAYS. To the President?

Mr. SCHATZ. To the President.

Mr. SHAYS. How about the Speaker, as well?

Mr. SCHATZ. Well, we will make sure that he is aware of what is going on. That happened to be the target we chose. But, in any event, there will be bright orange postcards arriving at the White House in the next several weeks, making the point that this is something that is critical to Medicare reform.

The GAO, of course, has reported Medicare was one of the Government programs it considered highly vulnerable to waste, fraud, abuse, and mismanagement. That was 1992. And again, earlier this year, while HCFA has made changes, they are still not sufficient to protect Medicare. You are aware of the various examples. In fact, in our report, we cite your own article from the Christian Science Monitor reporting an example of fraud and abuse.

It's a big system. Health care itself is a big system. It's constantly changing. There was discussion earlier about durable medical equipment and the pricing of some of the new technology that comes in. We held a hearing with the Coalition to Save Medicare several weeks ago, and Richard Kusserow, who is the former IG at HHS, made the point that, when you are looking at new technology, they can price it any way they want, because it seems to run through the system quickly.

People want to get the better care. And then they charge high prices, and they are unable, as was discussed in the previous panel, to really reduce that when competition starts coming in. I agree with the previous panel, that's a very, very important area, because the numbers that you're talking about are in the billions, without any question.

Mr. Chairman, your bill is a very, very important step in combatting the pervasive problem of waste, fraud, and abuse in health care. It has real teeth. It requires that the detection and prosecution of health care fraud be at the heart of the program.

I want to cite just three provisions, while we do support the bill, three very important and significant ones: establishing health care fraud as a crime, defining the crime and establishing fines and imprisonment; expanding the definition of fraud to include theft, embezzlement, false statements, bribery, graft, illegal remuneration, and obstruction of criminal investigations of health care fraud; and, finally, establishing rewards for information leading to prosecution and conviction of a Federal health care offense.

The director of the FBI, Louis Freeh, has previously testified, I believe it was over in the Senate, that drug dealers and organized crime, the Russian mafia, are all getting into the area of health care fraud. Clearly, they think this is an easier way to make money.

Throwing a few of them in jail for a long period of time, I think would be a great deterrent to what has previously been viewed as a simple white collar crime; it's easy to get away with it; nobody's watching the store. The chances of being audited under Medicare are 3 in 1,000, versus an IRS audit which is 2 in 100. It's very, very low-level.

One area that we would agree that more money should be spent is in providing more resources to the IG's office and to making sure that your bill does, in fact, work.

One quick comment, Mr. Chairman, is that you're requiring audits and reports to Congress by a number of agencies; we expect that those will be paid attention to. I know, under your leadership, they will. But we are concerned that you will have people sitting together, conferring about what to do, as opposed to going out and doing it. I hope that, as the oversight committee, you do make sure that action is taken and that the proper resources are being provided.

Mr. Chairman, I am sure you are aware of the red book from the Office of Inspector General. There's about $14 billion in here in savings that could be implemented. Many of them deal with the area of health care fraud and waste. We encourage you, if you have not already done so, to look at this. I know you have your bill moving forward, but to examine the recommendations that are already out there. Many of these date back to 1991, 1990, many in 1993, 1994, but they deserve great scrutiny by your subcommittee as you move this forward.

Again, Mr. Chairman, thank you. I will be happy to answer any questions.

[The prepared statement of Mr. Schatz follows:]

Testimony of
Thomas A. Schatz,
President of Citizens Against Government Waste
before the
House Government Reform and Oversight Human Resources Subcommittee
September 28, 1995

Good morning, Mr. Chairman. Thank you for the opportunity to testify today before the Government Reform and Oversight Human Resources Subcommittee. My name is Tom Schatz and I represent the 600,000 members of Citizens Against Government Waste (CAGW). I am honored to be asked to testify on the crucial issue of health care fraud and abuse.

CAGW recently published a report titled, ***Medicare Fraud: Tales from the Gypped.*** This report chronicles 89 examples of Medicare waste, fraud, and abuse. I would like to submit the report for the record. The information uncovered by the report and our research shows that the problems in Medicare are indicative of the problems in health care in general.

Medicare turned 30 years of age on July 30 of this year. Instead of enjoying the prime of its life like many 30-year olds, Medicare is in critical condition. This "illness" is life-threatening to the program which brings essential health care to our parents and grandparents. That is not only our judgment, but the judgment of the bipartisan trustees including the Secretaries of Treasury, HHS, Labor and the Committee on Social Security.

Preserving, protecting, and strengthening Medicare must be the number one priority for Congress. Medicare's Trustees have concluded that at its current rate of growth the Medicare trust fund will be bankrupt by the year 2002. They've told us that if we don't act today, never mind the long-range effect on baby boomers and their children; our parents and grandparents, who currently receive benefits, will be cut off in just seven years.

Medicare and its impending bankruptcy are too important to ignore the consequences of failing to act. Yet those who are fighting any reform claim that each dollar spent in the program produces a dollar in benefits for America's seniors...no waste, no fraud, no abuse. Nothing could be further from the truth. June Gibbs Brown, inspector general (IG) of the Department of Health and Human Services (HHS) has said that fraud and abuse permeate all aspects of Medicare. She has said that up to $17 billion, $46 million per day, or 10 percent of Medicare's budget, will be wasted because of fraud. Because of its size, diabolical complexity, and lax management practices, this $177 billion leviathan has become the equivalent of a Gucci-clad matron sauntering down the street sporting a flashing neon sign that says, "Please rob me!"

In the 1993 Fiscal Year, Medicare processed almost 700 million claims, or nearly two million per day. That's 250 million more than it processed five years earlier. That's nearly six times the number of tax returns processed by the Internal Revenue Service. Physicians, supply companies, or diagnostic laboratories have about three chances out of 1,000 of having Medicare audit their billing practices in any given year.

In 1992, the General Accounting Office (GAO) reported that hospitals owed Medicare over $170 million in overpayments, but contractors did little to reclaim the money. The Health Care Financing Administration (HCFA), which contracts with 80 private insurance companies to process Medicare claims, moreover, was unaware of contractor inaction because it had no systems to monitor this information. Contractors, who are paid process paper and not to investigate claims, paid an estimated $2 billion in claims that should have been paid by other health insurers.

The administration has recommended granting HCFA authority for competitive open bidding of Medicare claims processing contracts to reduce costs, improve quality of service, and eliminate inefficiencies and conflicts of interest. According to the administration, savings could total $985 million over five years.

In 1992, GAO reported that Medicare was one of several government programs it considered highly vulnerable to waste, fraud, abuse, and mismanagement. In early 1995, GAO reported that HCFA "has made various regulatory and administrative changes aimed at correcting flawed payment policies, weak billing controls, and deficient program management. However, these worthwhile improvements still are not sufficient to protect Medicare against continued program losses..., the Medicare program remains highly vulnerable to waste, fraud and abuse."

The Medicare program is a sitting duck for con artists, thieves and credentialed opportunists. Because of its size, complexity and lax management practices, the risks of gaming the $177 billion Medicare system are worth taking because Medicare is where the easy money is. Louis Freeh, director of the FBI, told a Senate subcommittee that the health-care system is being infiltrated by corrupt criminal enterprises in this country. Cocaine dealers are turning into health-care fraud entrepreneurs. Organized crime, including the Russian Mafia, has also gotten involved in this high-tech pilfering of the Treasury. According to Freeh, cocaine distributors in southern Florida and southern California are turning into Medicare fraud junkies. The chance of being caught and imprisoned are substantially less when defrauding the health-care system.

Medicare and health care fraud can be stopped. GAO compared what Medicare actually paid providers against what would have been allowed by four commercial firms that market computerized systems to detect miscoded claims. GAO invited each firm to reprocess 200,000 statistically selected claims that Medicare paid in 1993. On the basis of this sample, GAO estimated that, had Medicare used this commercial software, the government would have saved $3 billion over 5 years by detecting these billing abuses.

The following horror stories show the true depth and breadth of Medicare fraud. While some of these stories may seem humorous on the surface, they are not. Each story of Medicare being defrauded is a disgrace to working men and women in this country, and represents a serious breakdown of our system.

Under the Medicare and Medicaid anti-kickback statute, it is illegal to offer payments to physicians deliberately to induce them to refer business under Medicare or any state health-care program. Kickbacks are especially egregious because they encourage medical providers to replace concern for the patients welfare with the profit motive. Consider the following:

- According to the HHS IG, a former billing clerk and 14 former patients of a Georgia chiropractor were sentenced in a kickback scheme that cost Medicare and other insurance companies millions of dollars. Bills were submitted for 169 people who were supposedly treated in one day.

- In a report issued by Sen. William Cohen (R-Maine) in 1994, a doctor received kickbacks in the form of cash payments, jewelry, and other gifts in exchange for referrals. The total amount of kickbacks was estimated at $125,000.

An area of growing concern for the IG is Durable Medical Equipment (DME). DME is reimbursable by Medicare and Medicaid only if prescribed by physicians as medically necessary. Aggressive sales practices, such as telemarketing, are used to entice physicians into signing letters of medical necessity. According to the HHS IG, post office boxes or store fronts were used to disguise hundreds of bogus companies. For example:

- In a March 1995 article, *The Healthcare Financial Ventures Report* wrote that payments to about 2,000 DME suppliers have been suspended by HCFA because of suspicion of improper claims or billing fraud.

- Peter Vilbig, a writer for *The Las Vegas Review*, reported that angora underwear, microwaves, and air conditioners were used as ploys to get Medicare beneficiaries to give their identification numbers to a Brooklyn, New York firm. Medicare was apparently billed for expensive hospital beds and the company used part of the money to buy the promised item.

In 1992, GAO reported that funding for Medicare's contractors, who are responsible for combating fraud and abuse, had not been commensurate with the rapidly growing number of claims. In 1995, GAO concluded that "[B]etween 1989 and 1994, the requirement for contractors to review a portion of claims in process dropped from 20 percent to 5 percent due to reduced funding." This means that Medicare pays more claims with less scrutiny than at any other time over the past five years. Here are some of the results:

- GAO reported that a therapy company created a "paper company" with no space or employees and added $170,000 to its Medicare reimbursements over a six-month period while providing no additional services.

- Although speech and occupational therapy rates range from under $20 to $32 per hour, Medicare has been billed rates as high as $600 per hour, according to a report by the GAO.

- Several days after patients had died, a speech therapist submitted false claims to Medicare for "services rendered," according to Sen. Cohen's 1994 report.

Prescription marketing schemes are another area of vulnerability for Medicare fraud. When the deciding factor for the physician becomes which drug offers the greatest financial reward rather than the patients' well-being and comfort, not only are the health care needs of patients underserved, the costs of government programs and private health insurance programs are unnecessarily inflated. Consider these examples:

- In Michigan, large quantities of sample and expired drugs were dispensed to nursing home patients and pharmacy customers without their knowledge. When complaints were received from nursing home staff and patients' relatives regarding the ineffectiveness of the medications, one of the scam artists stated, "those people are old, they'll never know the difference and they'll be dead soon anyway."

And, Mr. Chairman, we cite your own valued contribution to uncovering this litany of horror stories as cited in the *Christian Science Monitor* on June 26, 1995:

- A Georgia health care company forced employees to make political contributions, then billed Medicare for reimbursement. The company also billed Medicare for golf trips, vacations, and a new car for the CEO's son. After indictment, the company declared bankruptcy. The court appointed receiver is still receiving Medicare payments.

These are not the only schemes perpetrated by scam artists. Other areas rife with abuse are: false, unnecessary, and non-existent tests, nursing homes and home care, ambulance and taxi services, selling tainted medical supplies, and outright embezzlement of Medicare funds.

I could go on and on with examples of Medicare waste, fraud, and abuse. But in the interest of time, and the need to take better care of taxpayers' money, I want to discuss some of the solutions. H.R. 2326, the "Health Care Fraud and Abuse Prevention Act of 1995" is an important step in combating this pervasive problem of waste, fraud, and abuse in health care and specifically Medicare. I was very pleased to see the introduction of this bill. For too long, the battle to reform Medicare has been one of sound-bites and accusations. Tackling Medicare reform is a true sign of keeping the commitment to change made to American taxpayers last November.

Medicare fraud can be stopped. According to GAO's high risk report in 1992, many Medicare beneficiaries call in to complain about waste and abuse, but contractors have often failed to investigate these complaints. When contractors do respond, results can be fruitful: follow-up on complaints about eye-care services, for example, led to a provider's agreement to refund over $2.5 million to the federal government.

If Medicare's centralized, non-competitive, single-payer system is at the heart of billions of dollars in wasted resources, eliminating waste, fraud, and abuse requires that competitive market forces be introduced into the Medicare system. Free market forces and incentives would reduce Medicare's excessive costs and improve the quality of health care for seniors. Moreover, we would finally provide seniors with a medical system that develops greater quality rather than a system that increasingly consumes more and more health dollars.

The Schiff/Shays Health Care Fraud and Abuse Prevention Act of 1995 is legislation with real teeth. The bill requires that the detection and prosecution of health-care fraud be at the heart of the program. The following provisions in the bill will go a long way in saving lives as well as tax dollars:

- require audits by the inspector general of Health and Human Services, Department of Defense, Office of Personal Management, Veterans Administration and Attorney General
- require that the IG and Attorney General to establish a joint program to prevent, detect and control health-care fraud which includes state agencies and local law enforcement
- establish health-care fraud as a crime, define the crime and establish fine and imprisonment
- expand the definition of fraud to include theft, embezzlement, false statements, bribery, graft, illegal renumerations and obstruction of criminal investigations of health care fraud, and
- establish rewards for information leading to prosecution and conviction of a federal health care offense

CAGW also commends the Majority leadership in the House for "The Medicare Preservation Act," which looks at all aspects of Medicare reform including eliminating, waste, fraud, and abuse.

Mr. Chairman, the most important provision in your bill is the establishment of health-care fraud as a crime. Too often people think of fraud as a victimless crime. This could not be further from the truth. Not only does the taxpayer get left holding the bag, but seniors are put at risk by receiving wrong or inadequate care. We owe more to the people who built our highways and railroads and fought our wars than a system that is open to treating seniors like chattel. Health-care fraud must be punished severely and swiftly.

Physicians, supply companies, or diagnostic laboratories have about three chances out of 1,000 of having Medicare audit their billing practices in any given year according to GAO. With this little oversight, white-collar criminals view the meager fines and penalties as merely the "cost of doing business." Organized crime and violent criminals are taking the lead of white-collar criminals and getting off the street and into an office. Instead of using armor-piercing bullets, white-collar thugs use pocket protectors and fax machines. Health-care fraud is a crime and must be treated as such. The criminalization of health-care fraud must be the first step. A few high profile cases with long terms of incarceration is the only way to send a message that this type of crime won't pay.

CAGW is concerned with a few provisions in this legislation. The bill requires audits and reports to Congress by a number of agencies. This could have the effect of fragmenting investigations, which could weaken enforcement. Spreading the enforcement activities could have a deleterious effect of the final goal of eliminating waste, fraud, and abuse in health care. The goal should be to bring the auditors together, not separate them.

The federal government already knows how to audit. The HHS IG's *1995 Red Book* shows that they know where the money is being wasted. There are more than 30 recommendations in the IG's *Red Book* that CAGW has endorsed, which could save more than $14 billion. For example:

- assess payment for oxygen concentrators
  One-Year Savings = $568 million Five-Year Savings = $4.2 Billion

- stop inappropriate payments for incontinence supplies
  One-Year Savings = $107 Million Five-Year Savings = $535 Million

- Take steps to prevent inappropriate payments for physical therapy in physician's offices.
  One-Year Savings = $47 Million Five-Year Savings = $235 Million

- Reduce Medicare payments for hospital outpatient services.
  One-Year Savings = $90 Million Five-Year Savings = $645 Million

I encourage and urge the members of this panel to look at those recommendations before creating any new bureaucracies to do virtually the same thing.

Putting the power of detection in the hands of the people who receive the care is a crucial step in ensuring that Medicare survives for future generations. This bill recognizes the importance of making the beneficiaries the critical point in detecting waste, fraud, and abuse. Streamlining whistle blower procedures is also important. If complaints get bogged down without any response, fewer and fewer people will be inclined to blow the whistle in the future.

When CAGW published its Medicare fraud report, we had a number of recommendations on how to eliminate waste, fraud, and abuse. Most important is the use of market forces in public health care. Allowing Medicare and all health-care providers to price services and procedures more competitively will bring costs down and eliminate waste.

Other CAGW recommendations include:

- Take steps to better protect Medicare from fraudulent provider billing practices, such as revise and strengthen national standards that suppliers and other providers must meet in order to renew a Medicare provider number, prohibit Medicare from issuing more than one provider billing number to an individual or entity, require Medicare to establish more uniform national coverage and utilization policies for what is reimbursed under Medicare, and require HCFA to review and revise its billing codes for supplies, equipment, and services in order to update, clarify, and standardize billing codes;

- Enact legislation to assure HCFA can adequately and consistently fund contractors' safeguard activities; and

- Require HCFA to assume a more active management posture over contractors' program operations

The Schiff/Shays bill sends the message to Medicare criminals that there is a new sheriff in town. We urge this Committee to move rapidly to bring this legislation before the full House. If you don't take the right steps now, there may never again be such an opportunity. This concludes my testimony.

I'll be pleased to answer any questions you may have.

A CAGW SPECIAL REPORT

MEDICARE FRAUD:
TALES FROM THE GYPPED

August 23, 1995

CITIZENS AGAINST GOVERNMENT WASTE

1301 Connecticut Ave., NW, Suite 400, Washington, D.C., 20036 (202) 467-5300

INTRODUCTION

"'The problem is that nobody is watching,' the doctor testified. 'Because of the nature of the [Medicare] system, I was able to do what I did. The system is extremely easy to evade. The forms I sent in were absolutely outrageous. I was astounded when some of those payments were made.'"[1] This statement was made in 1981 by a Philadelphia cardiologist before the Senate Special Committee on Aging. He was convicted in the early 1980's and was again arrested in 1994 for defrauding both public and private health insurers. People who defraud the system understand what they are doing and know the chances of getting caught are slim.

The Medicare program is a sitting duck for con artists, thieves, and degreed opportunists. Because of its size, diabolical complexity, and lax management practices, this $177 billion leviathan has become the equivalent of a Gucci-clad matron sauntering down the street sporting a flashing neon sign that says, "Please rob me!" Those with a notion to defraud Medicare know that these three factors alone guarantee that the risks of gaming the system are worth taking because Medicare is where the easy money is.

In Fiscal Year 1993, Medicare processed almost 700 million claims. That's nearly two million per day, about 250 million more than it processed five years earlier, and nearly six times the number of tax returns processed by the Internal Revenue Service. Physicians, supply companies, and diagnostic laboratories have about three chances out of 1,000 of having Medicare audit their billing practices in any given year.[2]

Medicare fraud is perpetrated by billing companies, providers, suppliers, even organized crime and drug dealers. There are scams involving kickbacks, durable medical equipment, prescription marketing, nursing homes and home-care providers, tainted medical supplies, ambulance and taxi services, and embezzlement. Medicare fraud is as varied as the imaginations of the criminals who game the system. Citizens Against Government Waste's (CAGW) new report, ***Medicare Fraud: Tales from the Gypped***, details 89 examples.

June Gibbs Brown, inspector general of the Department of Health and Human Services, said, "Fraud and abuse permeate all aspects of Medicare." She said up to $17 billion, $46 million per day, or 10 percent of Medicare's budget, will be wasted because of fraud.[3]

Is there any American surprised that 10 percent of Medicare spending is lost to waste, fraud, and abuse? Is there anyone surprised that Medicare spending is growing at a pace of 10 percent per year and rapidly approaching bankruptcy?

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[1] Minority Staff, Senate Special Committee on Aging, *Gaming the Health Care System*, July 7, 1994, p. 6.
[2] General Accounting Office (GAO), *High Risk Series: Medicare Claims* (GAO/HR-95-9), February, 1995, p. 27.
[3] Congressional Quarterly, *Congressional Monitor*, August 1, 1995, p. 7.

Medicare turns 30 years old in 1995. Instead of enjoying the prime of its life like many 30-year olds, Medicare is in critical condition. This "illness" is life-threatening to the program which brings essential health care to our parents and grandparents.

Preserving, protecting, and strengthening Medicare must be the number one priority for Congress and the administration. Medicare's Public Trustees have concluded that the program is faltering. The Trustees have given us a date for Medicare's certain demise if its current rate of spending is not reduced: 2002. They've told us that if we don't act today, never mind the long-range effect on baby boomers and their children; our parents and grandparents, who currently receive benefits, will be cut off in just seven years.

Medicare, which is made up of two separate programs, Medicare Part A and Medicare Part B, was created in 1965 to provide health-care insurance benefits to the aged and eligible populations who otherwise might not be able to obtain adequate health insurance coverage in the event of injury or illness.

Medicare Part A provides hospital and other institutional insurance for eligible disabled persons and persons 65 or older. This coverage is premium-free and is financed through mandatory payroll taxes. Part A finances the hospital insurance (HI) portion.

Medicare Part B, Supplementary Medical Insurance (SMI), is an optional program which covers most of the costs of medically necessary physician and other services. All persons 65 years or older can choose to enroll in the SMI program by paying a monthly premium. Even though this is a voluntary program, non-participating taxpayers finance most of the spending. "The current contribution level ($46.10 per month as of January 1, 1995) constitutes just 29 percent of the actual cost of the Part B program. The remaining 71 percent is provided by the taxpayers."[4]

The Health Care Financing Administration (HCFA) is the hub of the Medicare system. HCFA contracts with 80 private insurance companies to process Medicare claims annually and protect funds through review activities called payment "safeguards."

According to the General Accounting Office (GAO): "HCFA has not provided effective oversight of the contractors it uses to administer Medicare and safeguard program funds. HCFA has little information on fundamentals, such as the computerized edits and payment criteria used by contractors."[5] Medicare pays more claims with less scrutiny that at any other time over the past five years.[6]

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[4] Butler, Stuart M., Moffit, Robert E., and Liu, John C., "What to do About Medicare," Heritage Foundation, June 26, 1995, p. 3.
[5] GAO, *Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending*, (GAO/HEHS-84-42), April, 1994, p. 3.
[6] GAO, *High Risk Series*, February, 1995, p. 7.

In 1992, GAO reported that hospitals owed Medicare over $170 million in overpayments, but contractors did little to reclaim the money. HCFA, moreover, was unaware of contractor inaction because it had no systems to monitor this information.[7] Contractors paid an estimated $2 billion in claims that should have been paid by other health insurers.[8]

The administration has recommended granting HCFA authority for competitive open bidding of Medicare claims processing contracts to reduce costs, improve quality of service, and eliminate inefficiencies and conflicts of interest. According to the administration, savings could total $985 million over five years.

In 1992, GAO reported that Medicare was one of several government programs it considered highly vulnerable to waste, fraud, abuse, and mismanagement. In early 1995, GAO reported that HCFA "has made various regulatory and administrative changes aimed at correcting flawed payment policies, weak billing controls, and deficient program management. However, these worthwhile improvements still are not sufficient to protect Medicare against continued program losses..., the Medicare program remains highly vulnerable to waste, fraud and abuse."[9]

Medicare fraud is not a victimless crime. Taxpayers and program beneficiaries will continue to be the prey for the vultures that continually circle the Medicare system looking for easy pickings.

GAO reports that:

- In 1994 more than $300 million in fines, damages, and penalties for fraud, kickbacks, and abusive billing practices was paid by a national psychiatric hospital chain which was charged with committing fraudulent practices. This was the largest such settlement ever paid to the federal government.[10]

- Medicare was overbilled tens of millions of dollars for lab tests by two of the nation's largest clinical laboratories from 1988 to 1991.[11]

- One nursing home resident was billed for therapy charges of $8,425, more than one-half of which -- $4,850 -- was for charges added by the billing service for submitting the claim. "Such practices escape notice because for institutional providers, Medicare allows almost any patient-related costs that can be documented."[12]

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[7] GAO, *High-Risk Series: Medicare Claims* (GAO/HR-93-6), December, 1992, p. 7.
[8] *Idem.*
[9] GAO, *High-Risk Series,* February, 1995, pp. 6-7.
[10] *Ibid.,* p. 20.
[11] *Idem.*
[12] GAO, *Medicare, Modern Management Strategies Could Curb Fraud, Waste and Abuse,* (GAO/T-HEHS-95-227), July 31, 1995, p. 3.

In mid-August, 1995, the U. S. Attorney for the Southern District of Florida announced a major indictment against a $120-million Medicare scam which included an integrated business of suppliers, providers, and physicians established for the main purpose of ripping off the system. Health-care fraud is so pervasive in southern Florida that the FBI has established a special task force.

Many Medicare beneficiaries call in to complain about waste and abuse, but contractors have often failed to investigate these complaints. When contractors do respond, results can be fruitful: follow-up on complaints about eye-care services led to a provider's agreement to refund over $2.5 million to the federal government.[13]

Despite this evidence of fraud and waste and failure to take adequate steps to eliminate the abuses, rhetoric and denial are the postures of choice in Washington. Some members of Congress, along with their outside supporters, claim there is no crisis. Others argue that the federal government will never let the system run out of money, as if the American taxpayer is a never-ending source of cash for this vital, but floundering, program. And then there are those, like Minority Leader Richard Gephardt (D-Mo.), who can't resist the easy politics of fear.

But Republican attention to Medicare's problems is not some partisan plot. Mr. Gephardt ought to familiarize himself with the authors of the 1995 Trustees' Report, which included such Republican friends as Treasury Secretary Robert Rubin, Labor Secretary Robert Reich, Health and Human Services Secretary Donna Shalala, and Social Security Commissioner Shirley Chater.

Other members of Washington's political establishment also seem to feel that it is politically advantageous to demonize those who want to reform Medicare. Consider the following:

> Today, Medicaid and Medicare are going up at three times the rate of inflation. We propose to let it go up at two times the rate of inflation. That is not a Medicare or a Medicaid cut. So when you hear all this business about cuts, let me caution you that is not what is going on.[14]

If you didn't peek at the footnotes, you may have guessed that the previous quote was from the Republicans in early 1995 when they proposed to reduce the growth of Medicare spending. This quote is actually from President Clinton in a speech to the American Association of Retired Persons (AARP) in 1993. Confusing rhetoric, considering that the Republicans are proposing to do the same thing while the administration is criticizing the Republicans for "cutting" Medicare and for using those savings to pay for a tax cut for "the rich." But the President's remarks were made two

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[13] GAO, *High-Risk Series,* December, 1992, p. 7.

[14] Address of President Bill Clinton to the American Association of Retired Persons, Culver City, California, October 5, 1993.

years before any tax cut was proposed, and even AARP recognizes Medicare must be saved from bankruptcy. Even if we had a balanced budget today, Medicare would still be going broke, and changes would be required to save it.

While the focus is on the next seven years, what about the long-term future? In just 16 years, the first of the baby boomers will be eligible for retirement. In the next 35 years, the number of Americans over the age of 70 will double.[15] At the same time, the number of workers supporting Medicare will shrink. Just five years ago, there were almost five workers for each retiree. In just 35 years, there will be fewer than three workers for each retiree.[16]

The consequences of failing to act now are devastating: massive increases in payroll taxes or drastic cuts in Medicare spending, along with major increases in premiums for senior citizens.

How we deal with Medicare's crisis will speak volumes about who we are as Americans and what kind of society we value. At stake is whether today's senior citizens, not to mention those of us who are following close behind, will have a viable health-care system for decades to come. Waste and fraud will only rob us all of a better future if we continue to assume it is an unavoidable result of a well-meaning, big government program.

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[15] Bipartisan Commission on Entitlement and Tax Reform, *Final Report*, January, 1995, p. 13.
[16] *Ibid.*, p. 16.

COMBATING HEALTH-CARE FRAUD

Attorney General Janet Reno has made health-care fraud her number two new initiative after violent crime. "For the first time, there are criminal and civil health care fraud coordinators in each United States Attorney's Office. By the end of the year, most offices will be sponsoring health care fraud working groups. ... At present, the FBI is expending approximately 300 FBI agent work years handling these cases, up from 163 FBI agent work years at the end of last fiscal year. The FBI anticipates that this number could rise to 450 by the end of the next year. As of June 1994, the FBI had 1,361 pending health care fraud cases, up from 657 in November 1992."[17]

"The Department of Justice had 1,041 criminal health care fraud matters open in August 31, 1994, a 158 percent increase over the 621 matters pending in fiscal year 1993. Eight hundred and ninety-nine civil health care fraud matters were pending as of August 31, 1994, a 119 percent increase over the 411 pending in fiscal year 1993."[18]

The numbers of defendants charged and convicted have also increased. As of August 1994, 224 defendants have been charged, a 67 percent increase over the 157 charged in fiscal year 1993. The number of defendants convicted also increased during this period, and there were often long sentences. For example: two men who had perpetrated a health care fraud in California involving millions of dollars and 1,400 insurance companies were sentenced to more than 20 years' imprisonment each, plus restitution and forfeiture orders.[19]

GAO not only identifies problems with Medicare but it is also exploring possible solutions. "We compared what Medicare actually paid providers against what would have been allowed by four commercial firms that market computerized systems to detect miscoded claims. We invited each firm to reprocess 200,000 statistically selected claims that Medicare paid in 1993. On the basis of this sample, we estimated that, had Medicare used this commercial software, the government would have saved $3 billion over 5 years by detecting these billing abuses."[20]

Combating Medicare fraud is not a quixotic exercise. Fraud and abuse can be stopped.

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[17] Statement of Gerald M. Stern, Special Counsel for Health Care Fraud, before the House Small Business Subcommittee on Regulation, Business Opportunities and Technology, October 12, 1994, pp. 1-2.
[18] *Idem.*
[19] *Idem.*
[20] GAO, *Medicare, Modern Management Strategies*, p. 4.

ORGANIZED CRIME AND THE DRUG TRADE

Organized criminal enterprises have penetrated virtually every legitimate segment of the health care industry.[21] Louis J. Freeh, director of the FBI, told a Senate committee that the health-care system is being infiltrated by corrupt criminal enterprises in this country. "Health care fraud is a very serious crime problem in the 1990s," he testified before the Special Committee on Aging. "Today, we see cocaine dealers turning into health care fraud entrepreneurs. The Russian Mafia, as well as other organized crime groups are engaged in creative schemes to siphon money from government and private health-care trust funds."[22]

Cocaine distributors in southern Florida and southern California are turning into Medicare fraud junkies. The chance of being imprisoned and caught are substantially less when defrauding the health-care system. "Drug dealers who are committing health care fraud know that they likely will face only minor punishments because law enforcement is not yet equipped with the laws needed to effectively attack this problem."[23]

The criminals' imaginations are the only limits to the list of schemes being perpetrated. The common factor in each investigation is the corruption of the business side of medical care. The system is built on payers who must trust those who submit claims for medical services, medications, treatments, and supplies, whether it is a government agency, private insurer, or private citizen.[24]

- "A New York physician was excluded from the Medicare and state health programs for 15 years after being convicted of distributing a controlled substance. The physician had accepted thousands of dollars of payoffs from drug dealers in exchange for writing thousands of illegal prescriptions. The drug dealers used the prescriptions to obtain controlled substances from pharmacies. The physician has been sentenced to 12 years and 7 months in prison."[25]

- "A Pennsylvania endocrinologist was sentenced to 34 months imprisonment and 3 years probation, and fined $20,000 for Medicare fraud and illegal drug distribution. The endocrinologist took blood and urine samples which he never sent to the lab, but he billed Medicare as if tests had been performed. He was also illegally prescribing and distributing Dexedrine. In a subsequent civil judgment, he and his organization were ordered to pay $2.3 million."[26]

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[21] Statement of Louis J. Freeh, director, Federal Bureau of Investigation, before the Senate Special Committee on Aging, March 21, 1995, p. 2.
[22] "FBI Chief: Criminal Element Infiltrating Health Care," *National Underwriter Life and Health*, April 3, 1995.
[23] Statement of Louis J. Freeh, p. 2.
[24] *Idem.*
[25] Department of Health and Human Services (HHS), Office of Inspector General (OIG), *Semiannual Report*, April 1, 1993 - September 30, 1993, p. 21.
[26] *Ibid.*, pp. 17-18.

- "An Ohio dentist was sentenced to 1 1/2 years confinement, to be served consecutively, on 15 counts of selling controlled drugs to patients.... This case was developed from Project Pharm-Div, a joint [Office of Inspector General] OIG and Cincinnati police department undercover operation. The project aimed at identifying and prosecuting individuals involved in the abuse of pharmaceutical drugs, fraud against Medicare and Medicaid, and various frauds involving the misuse of Social Security numbers. To date, 16 individuals and entities have been prosecuted in federal and state courts as a result of the project."[27]

- "... rolling laboratories, which operate in vans that move from place to place, advertise for free health screening. In practice, the patients' insurance companies are billed for unnecessary tests or no tests at all. Unscrupulous providers who can obtain the insurance information bill companies for patients who have never been seen. Tests on a single individual have involved billings as high as $40,000."[28]

- The elderly and Alzheimer's patients have been exploited by nursing home and hospice operators who fraudulently billed services, incontinence supplies and medications. These criminals prey on these victims because of their lapses of memory or difficulty understanding these illegal activities.[29]

KICKBACK SCAMS

Referrals are an integral part of the health-care system, especially Medicare, because of the countless specialties in the medical profession. The giver and receiver may violate federal anti-kickback statutes if referrals of Medicare or Medicaid are made in exchange for something of value. Under the Medicare and Medicaid anti-kickback statute, it is illegal to offer payments to physicians deliberately to induce them to refer business under Medicare or any state health-care program.

Kickbacks are especially egregious because they encourage medical providers to replace concern for the patient's welfare with the profit motive. Kickbacks can result in totally inappropriate medical care, including unnecessary surgery, hospitalization, tests, and equipment.[30] Consider the following:

- "The former billing clerk and 14 former patients of a Georgia chiropractor were sentenced in a kickback scheme costing Medicare and more than 30 insurance companies millions of dollars.... Claims were submitted for patients and their

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[27] HHS, OIG, *Semiannual Report*, October 1, 1994 - March 31, 1995, p. 9.
[28] Garrett, Thomas M., Klonoski, Richard J., and Baillie, Harold W., "American Business Ethics and Health Care Costs," *Health Care Management Review*, Vol. 18, Issue No. 4, September 22, 1993.
[29] Statement of Louis J. Freeh, p. 2.
[30] Statement of Gerald M. Stern, p. 2.

families regardless of whether they were treated. In one instance, bills were submitted for 169 persons supposedly treated in one day."[31]

- "In Florida, five persons were sentenced as the result of a continuing investigation into a conspiracy in which Medicare was fraudulently billed about $5.2 million for oxygen concentrators, nebulizers, medications and tests. Three men were ordered to pay $2.3 million in restitution, and were sentenced to 41, 46, and 51 months in jail, for paying physicians for prescriptions which they sold to two medical supply companies and a laboratory to use in billing Medicare."[32]

- "A second Florida investigation involving kickbacks to physicians for prescriptions for unnecessary medical supplies also resulted in five sentencings during this period. More than a dozen companies, set up supposedly to supply Medicare patients with liquid nutritional supplements and feeding kits, defrauded Medicare of an estimated $20 million. A man and woman who operated some of the companies paid recruiters to sign up senior citizens for 'free milk' (for which they billed Medicare) and were sentenced to 51 and 24 months in prison respectively. They are to make restitution of more than $4.6 million. Another woman who did the billing for several of the companies was sentenced to 5 months in prison and ordered to pay restitution and fines over $251,000. Two physicians who were paid for signing blank certifications for patients, regardless of the medical necessity or their eligibility, were sentenced to 30 and 12 months in prison and ordered to pay a total of almost $865,000. Others await sentencing. The 'kingpin' of the scheme fled the country but was found in Venezuela and extradited."[33]

- "A cardiologist has been charged with receiving $125,000 in kickbacks from a Durable Medical Equipment (DME) company that enables the company, which supplied oxygen and respiratory aids, to bill government programs for hundreds of thousands of dollars. The indictment claims the doctor received kickbacks in the form of cash payments, jewelry, and other gifts in exchange for referrals."[34]

- A Florida clinic owner and operator was sentenced to a year and a half in prison for paying illegal kickbacks for patient referrals and filing false Medicare and Medicaid claims. "Recruiters" were frequently paid $5 to $10 for each eligible Medicare/ Medicaid beneficiary that they brought into the clinic by the owner. Patients were also paid for directly coming in and bringing their children into the clinic. The clinic owner was ordered to make restitution of $129,000 he received by submitting false claims for these individuals.[35]

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[31] HHS, OIG, *Semiannual Report*, October 1, 1993 - March 31, 1994, p. 17.
[32] *Idem.*
[33] *Idem.*
[34] *Gaming the Health Care System*, pp. 14-15.
[35] HHS, OIG, *Semiannual Report*, April 1, 1993 - September 30, 1993, p. 25.

- A Georgia hospital agreed to pay $75,000 and undertake corrective action in the future in lieu of legal proceedings for violations of the Medicare/Medicaid anti-kickback statute. It was established by the OIG that the hospital had offered illegal remuneration to physicians, such as below-market leases for office space, to induce the referral of patients to the hospital.[36]

- A home infusion company paid $500,000 to reimburse Medicare for damages and for investigation costs to avoid action against it for certain business practices with physicians. "The company used several business arrangements to induce physician referrals, including offering restricted stock for physicians in infusion centers the company managed and otherwise tying their profits to referrals to the company."[37]

- "A Pennsylvania laboratory agreed to pay $2.4 million in settlement of claims that it defrauded Medicare by manipulating doctors into ordering medically unnecessary tests. In mid-1987, the laboratory informed its doctor-clients that they would automatically receive the results of a ferritin test, which estimates iron storage, with every basic blood test series they ordered. The doctors were billed a nominal fee for the series, but the ferritin tests were billed separately to Medicare at the maximum rate allowable. Since Medicare covers only tests which doctors have said are medically necessary, the laboratory was causing false claims to be submitted when it substituted its judgment for the doctor's judgment."[38]

DURABLE MEDICAL EQUIPMENT SCAMS

DME is a growing area of fraud, scandal, and concern. DME is reimbursable by Medicare and Medicaid only if prescribed by physicians as medically necessary. This requirement is easily circumvented through aggressive sales practices, such as telemarketing, pressuring physicians into signing certificates of medical necessity, persuading physicians to act in complicity with a fraudulent scheme, or forging physician signatures.[39]

DME fraud continues to be a serious problem and often involves the most intricate schemes. Authorities recognized the need for a new anti-fraud initiative after a spate of such cases in southern Florida. Post office boxes or store fronts were used to disguise hundreds of bogus companies.[40]

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[36] HHS, OIG, *Semiannual Report*, October 1, 1993 - March 31, 1994, p. 18.
[37] *Idem.*
[38] *Ibid.*, p. 14.
[39] *Gaming the Health Care System*, p. 6.
[40] Vilbig, Peter, "Federal Government Targets Medicare and Medicaid Fraud," *The Las Vegas Review-Journal*, July 11, 1995, p. 3C.

- Payments to about 2,000 DME suppliers have been suspended by HCFA because of suspicion of improper claims or billing fraud.[41]

- "A group of Florida DME companies supplied respiratory equipment to Medicare beneficiaries without any prior physical examinations of the patients or authorization for the equipment. After the companies delivered the equipment, they paid kickbacks to physicians who agreed to write prescriptions for the equipment and medication, without ever seeing the patients. The companies then used the prescriptions as supporting documentation to obtain over $5.2 million in Medicare reimbursements.[42]

- "The owner of a DME company in New York was sentenced to five months in jail for Medicare fraud and ordered to pay $100,000 in restitution for falsifying blood tests to justify claims for oxygen equipment and inflating hours of oxygen use to obtain higher reimbursements."[43]

- "In Florida, an investigation of physicians, middlemen and DME companies involved in selling and buying Certificates of Medical Necessity led to indictments and imprisonment. One physician was sentenced for selling the certificates for patients he neither examined nor treated, knowing full well they would be used in filing Medicare claims. Other individuals and companies are also under indictment as part of the overall investigation."[44]

- Body-jacket scams have been increasingly popular. "In Texas, the president of a DME company, one of his partners, the former company manager and the owner of a nursing home became the last of seven persons sentenced for Medicare fraud involving false billings and kickbacks.... They had participated in a scheme in which the company billed Medicare for body jackets when it really provided seat pads. The seat pads were manufactured in Mexico for $50 each, but Medicare was billed $800. Over a 2-year period, the company billed Medicare more than $1.6 million, which the company officials were ordered by the court to repay."[45]

- A Michigan husband and wife team allegedly stole more than $25 million from Medicare in false claims for incontinence supplies for nursing home patients. In order to escape detection, the team would incorporate a new company when they got close to being caught.[46]

- Angora underwear, microwaves, and air conditioners were used as ploys to get Medicare beneficiaries to give their identification numbers to a Brooklyn, New York

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[41] "HCFA Suspends Payments to 2,000 DME Suppliers," *Healthcare Financial Ventures Report*, March 22, 1995, p. 3.
[42] *Gaming the Health Care System*, p. 6.
[43] *Ibid.*, p. 15.
[44] *Ibid.*, p. 16.
[45] HHS, OIG, *Semiannual Report*, October 1, 1994 - March 31, 1995, p. 18.
[46] *Gaming the Health Care System*, p. 16.

firm. "Investigators say the company billed Medicare for expensive hospital beds and used part of the money to buy the promised item."[47]

- "The president and owner of an Arkansas DME company was sentenced to 12 months home detention for billing Medicare for equipment not requested or supplied. He also billed for hospital beds he claimed to have put in the homes of Medicare recipients, when he really delivered sealift chairs. The owner pled guilty, agreeing to pay the government $1.5 million to settle claims against him and his company."[48]

- "In California, five persons, including three physicians, were sentenced and another five pled guilty in a DME kickback scheme. A DME company was set up to pay physicians, independent contractors and sales agents for referral of patients for prescriptions for transcutaneous electrical nerve stimulators (TENS). The company billed Medicare $2 million for the TENS units, and was paid $475,000."[49]

- "The owner of several DME companies was sentenced in Georgia to a year and a day for defrauding Medicare and Medicaid. The owner engaged telemarketers to contact beneficiaries, ask about physical problems and offer DME at no charge. The telemarketers were given a list of physicians ranked from 1 to 5, with a 1 indicating they would sign anything and a 5 if they refused to sign DME certifications. The telemarketers asked the beneficiaries about physicians who treated them, to identify a more compliant physician if the first one they named was rated a '5.' The owner was fined $5,000 and ordered to serve 300 hours public service. Recoveries totaled $199,500."[50]

- "A Michigan DME company and its four co-owners agreed to pay $626,000 to settle allegations that the company submitted false and inflated claims for Medicare reimbursement. They convinced senior citizens that they needed DME such as transcutaneous electronic nerve stimulators, claiming they would owe no co-payment because Medicare would pay the entire cost. They never attempted to collect deductibles and co-payments, thereby inflating by 20 percent each claim submitted for Medicare-eligible customers."[51]

- "The prosthetist owner of a California orthopedic center was charged with submitting false Medicare claims for 44 orthotic bilateral contracture devices for nursing home residents that he never provided. After the investigation was underway and the carrier began withholding reimbursement, the prosthetist set up a second business under a friend's name and submitted more false claims under the friend's provider number."[52]

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47 Vilbig, Peter.
48 HHS, OIG, *Semiannual Report*, April 1, 1993 - September 30, 1993, p. 30.
49 HHS, OIG, *Semiannual Report*, October 1, 1993 - March 31, 1994, p. 18.
50 HHS, OIG, *Semiannual Report*, April 1, 1994 - September 30, 1994, p. 23.
51 *Idem.*
52 *Idem.*

- "In New York one of the owners of a DME company was sentenced for Medicare fraud and income tax evasion. He was sentenced to 2 years imprisonment, suspended on condition that he serve 3 months over 30 consecutive weekends. Two other persons await sentencing in the case, in which Medicare was defrauded of $2.7 million. Until they are sentenced the owner is responsible for a repayment of $900,000 settled in a civil agreement."[53]

- "An Illinois DME company and its president agreed to a $68,000 settlement of allegations of billing Medicare for supplies not provided, falsifying physician's signatures on medical necessity forms, adding and whiting out information on the forms, and substituting equipment of a lesser type than that billed.... During the investigation, the company vice president who actually ran its operations fled to Iraq. The settlement included proceeds from the sale of the vice president's home and other assets, and an additional amount from the president, the DME company and a related company of which he was also president, for a total payment of $122,000."[54]

- In Michigan, a pharmacy and its former office manager were found guilty of Medicare and Medicaid fraud. "They had billed for urinary incontinence and decubitis ulcer kits which were neither related to the patients' conditions nor medically necessary. They also billed for greater quantities than delivered. The office manager was suspended from program participation in 1988 for 5 years because of a racketeering charge involving illegal drugs, and he was office manager of the pharmacy while under suspension. He has since set up several new businesses in Florida."[55]

FRAUDULENT BILLING: GAMING THE SYSTEM

In 1992, GAO reported that funding for Medicare's contractors, who are responsible for combating fraud and abuse, had not been commensurate with the rapidly growing number of claims. In 1995, GAO concluded that "[B]etween 1989 and 1994, the requirement for contractors to review a portion of claims in process dropped from 20 percent to 5 percent due to reduced funding."[56] This means that Medicare pays more claims with less scrutiny than at any other time over the past five years. Here are some of the results:

- A therapy company created a "paper company" with no space or employees and added $170,000 to its Medicare reimbursements over a six-month period while providing no additional services. "The company simply reorganized its nursing home and therapy businesses so that a large portion of its total administrative costs could be allocated to Medicare."[57]

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[53] *Ibid.*, p. 24.
[54] HHS, OIG, *Semiannual Report*, October 1, 1994 - March 31, 1995, p. 20.
[55] *Ibid.*, p. 10.
[56] GAO, *High-Risk Series*, February, 1995, p. 7.
[57] GAO, *Medicare, Modern Management Strategies*, p. 6.

- More than 20 different Medicare provider numbers were obtained by a medical supply company which served nursing facility patients. "The companies, all in the same state, were nothing more than shells that allowed the supplier to spread its billings over numerous provider numbers to avoid detection of its overbillings."[58]

- Although speech and occupational therapy rates range from under $20 to $32 per hour, Medicare has been billed rates as high as $600 per hour. Extraordinary markup in the charges for services is the result of certain weaknesses in payment rules permitted by Medicare.[59]

- "A speech therapist submitted false claims to Medicare for services 'rendered to patients' several days after they had died."[60]

- "Five clinical labs (to which Medicare paid over $15 million in 1992) have been under investigation since early 1993 for the alleged submission of false claims. The labs' mode of operation was to bill Medicare larger sums over 6 to 9 months; whenever a lab received inquiries from Medicare, it went out of business."[61]

- A California supply company billed Medicare for $5 million worth of surgical dressings for patients who never underwent surgery.[62]

- "A Georgia health care company forced employees to make political contributions, then billed Medicare for reimbursement. The company also billed Medicare for golf trips, vacations, and a new car for the CEO's son. After indictment, the company declared bankruptcy. The court appointed receiver is still receiving Medicare payments."[63]

- "In Illinois, a physician's wife was sentenced to 2 years probation and community service, and ordered to pay restitution of $5,200 and a fine of $3,000 for defrauding Medicare and Medicaid. The woman, who served as office manager and billing clerk for her husband, devised a scheme to file Medicare and Medicaid claims for services not rendered. She admitted submitting approximately 370 fraudulent claims over a 2 1/2-year period."[64]

- "A Florida man was sentenced to 13 months incarceration for impersonating a physician and submitting false claims to Medicare, the Civilian Health and Medical Program of the Uniformed Services and private insurance programs. After a

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[58] *Idem.*
[59] GAO, *High-Risk Series*, February, 1995, p. 8.
[60] *Gaming the Health Care System*, p. 6.
[61] GAO, *Medicare, Modern Management Strategies*, p. 6.
[62] *Gaming the Health Care System*, p. 21.
[63] Shays, Christopher, "To Fix Health Care, Stop Fraud," *Christian Science Monitor*, June 26, 1995, p. 20.
[64] HHS, OIG, *Semiannual Report*, April 1, 1993 - September 30, 1993, p. 18.

pharmacist's report that a particular physician was prescribing large amounts of controlled substances, it was found that the physician had died in 1986. An attorney who had been a friend of the physician had intercepted a letter from Florida, acted as medical director of a clinic, then opened his own clinic with his wife as office manager. He was ordered to pay more than $113,800 in restitution, $45,800 of it to Medicare."[65]

- "A New York man and his wife were sentenced for conspiracy to defraud Medicare, workers' compensation, and numerous private insurance companies of more than $1 million. The man, a registered physical therapist, was sentenced to 27 months incarceration and 3 years probations, and ordered to make restitutions of $125,000 and to pay a $50 fine. His wife was sentenced to 2 years probation and a $50 fine. The couple submitted bills for no-show appointments, canceled appointments and services not rendered."[66]

- "In Connecticut, the husband and wife owners of an acupuncture center, the center itself and three physician employees were sentenced for filing false Medicare claims and evading taxes. The owners performed acupuncture treatments but billed them as physical therapy performed by the doctors."[67]

- A Pennsylvania osteopath, who had earlier been excluded from participating in Medicare and state programs for possession of cocaine, was sentenced to 15 months in prison for defrauding Medicare and Blue Shield of close to $90,000 over a four-year period. He was ordered to pay full restitution and a $400 special assessment. The claims were for removing foreign bodies from patients' ears when he actually performed ear irrigations and upgraded procedural codes to reflect costly hepatitis panels. He then submitted altered patient medical records to cover up the false claims.[68]

- "A Utah physician and clinic owner was convicted on 32 federal counts of mail fraud, submitting false claims, and aiding and abetting. Although he was excluded from participating in Medicare and state health care programs in 1987 for similar crimes, he continued to submit claims under the names and provider numbers of physicians who performed services at his clinic. He also upcoded claims and billed for services not rendered. He was sentenced to 56 months in prison and 3 years probation upon release, fined $50,000, and assessed a special victim's assessment fee of $1,600. Restitution will be decided by the probation office."[69]

- "A Virginia psychiatrist was order to pay $48,000 in fines and restitution for illegally billing seven insurance programs, including Medicare, Medicaid and the Civilian

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[65] *Ibid.*, p. 19.
[66] HHS, OIG, *Semiannual Report*, October 1, 1993 - March 31, 1994, pp. 7-8.
[67] HHS, OIG, *Semiannual Report*, April 1, 1993 - September 30, 1993, p. 18.
[68] HHS, OIG, *Semiannual Report*, October 1, 1993 - March 31, 1994, pp. 8-9.
[69] *Ibid.*, p. 9.

Health and Medical Program of the Uniformed Services. He billed for counseling sessions that never occurred or inflated time. He was ordered to serve 6 months home confinement and 750 hours community service."[70]

- "A Florida ophthalmology group agreed to pay $2.5 million to resolve civil claims arising from two fraudulent Medicare billing schemes. The first scheme involved billing for services under an erroneous code to obtain maximum reimbursement for laser surgeries. The second scheme involved a contract with a billing service which resubmitted to Medicare fraudulent claims for individual procedures already reimbursed under global payments. The billing service, which is now defunct, solicited medical groups throughout the country and contracted to review their billing records to ensure full reimbursement. The billing service kept 50 percent of any additional reimbursement it identified and received for a group."[71]

- "A California orthopedic surgeon agreed to pay a total of $581,500 to settle charges of submitting false claims for Medicare reimbursement. The surgeon billed for services performed while he was out of the country, and billed for x-ray and physical therapy services that were performed by unlicensed, untrained personnel. The surgeon was convicted of theft from the Medi-Cal program in 1987 for filing similar false claims and was excluded from the Medicare and state health care programs for 25 years."[72]

- "A county hospital in Maryland agreed to pay $275,000 to settle government claims related to fraudulent Medicare billings. The hospital billed for physical therapy services for which physician certification orders were altered or nonexistent. A review of 392 Medicare claims showed that 236 were improper."[73]

- "A private non-profit corporation in Michigan and its president paid a total of $150,000 for submitting false claims to Medicare. The corporation charged for physical therapy services for community mental health clients when they actually provided exercise therapy and counseling to improve motivation, endurance, general health and socialization -- which are not covered by Medicare. The corporate president duped two local doctors into permitting use of their provider numbers for billing purposes. The doctors turned over to him the payments received."[74]

- A California Superior Court judge rejected an offer to allow a convicted ophthalmologist to spend a year performing eye surgery in an impoverished country and ordered him to begin serving his 16-month prison sentence. The ophthalmologist was convicted in 1991 in state court on 36 counts of grand theft for billing Medicare for services he did not perform. He intentionally caused astigmatisms by sewing a

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[70] *Idem.*
[71] HHS, OIG, *Semiannual Report*, April 1, 1993 - September 30, 1993, pp. 23-24.
[72] HHS, OIG, *Semiannual Report*, October 1, 1993 - March 31, 1994, p. 14.
[73] *Idem.*
[74] *Idem.*

stitch too tightly in patients undergoing cataract surgery. "When the patients returned complaining of vision problems, he cut the stitch and normal vision returned. The stitch was billed to Medicare as a $2,000 corneal transplant. During a 4-year period, he billed Medicare more than $1.3 million for over 680 eye operations."[75]

- "The owner of a New York retail optical store was sentenced to 6 months probation and ordered to repay $24,000, with further prosecution underway for submitting false Medicare claims. From January 1989 until June 1993 Medicare paid him $237,000, of which $180,000 was overpayment. He billed for eyeglasses not provided or misrepresented services to receive payment when none would have been allowed."[76] When confronted by federal agents, the optical dealer made a complete written confession about his fraudulent dealings.

- In February, 1992, a California oncologist was excluded for a period of 10 years because he rendered over 3,900 excessive, unnecessary, and potentially risky services to seven Medicare beneficiaries over a relatively short time period. An administrative law judge found that the doctor "had jeopardized the patients' health while depriving them of the opportunity to receive treatment that could have abated or cured their cancers. Further, the doctor had caused the patients unnecessary suffering by having them endure numerous, prolonged infusions of subtherapeutic dosages of chemotherapy with repeated blood tests and vitamin injections of marginal efficacy."[77] The judge found that "the doctor's record of unnecessary and excessive treatment, when combined with his refusal and inability to follow standard Medicare billing practices, demonstrated the doctor's eagerness to generate the maximum amount of Medicare billings and raised questions about whether services had been provided as claimed in the patient records."[78]

- A physician in West Virginia agreed to pay $1.25 million to resolve allegations of fraudulent billing of Medicare, Medicaid, the Railroad Retirement Board, and the Civilian Health and Medical Program of the Uniformed Services and violations of the federal anti-kickback statute. "The physician submitted a large number of false Medicare claims for unnecessary surgery, and had treated patients for glaucoma and cataracts when they did not have these conditions. The hospital with which he had a kickback arrangement signed a civil settlement earlier."[79]

- In Pennsylvania, an ophthalmologist and his corporation agreed to pay $625,000 to settle charges that he had submitted false Medicare claims. "The ophthalmologist billed for procedures not performed or not medically necessary, and for upgrading routine services Medicare would not have compensated. He did not even have the equipment to perform one procedure for which he billed. As one of the terms of

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[75] HHS, OIG, *Semiannual Report*, October 1, 1994 - March 31, 1995, pp. 8-9.
[76] *Ibid.*, p. 10.
[77] *Ibid.*, p. 15.
[78] *Idem.*
[79] *Ibid.*, p. 19.

settlement, he agreed not to bill Medicare or any state health care program for 2 years."[80]

NURSING-HOME AND HOME-CARE FRAUD

Federal investigators are targeting what investigators call the fastest-growing area of Medicare and Medicaid fraud: nursing homes and home-care agency fraud. While the amount of nursing home and home-care fraud is unknown, "nursing home and home-care payments totaled $55 billion in 1993 -- up from $38 billion in 1990."[81] It is fertile ground for the unscrupulous opportunist.

Investigators have targeted DME scams involving hospitals and doctors for years, but "many of the new cases involve the use of such equipment in nursing homes and home care agencies."[82] Home-care agencies have often been implicated for billing Medicare or Medicaid for services never provided to patients or billing for services rendered by untrained, unqualified staff. In some cases, Medicare and Medicaid funds have been used to support other business interests of the home-care owners.

- According to Bill Lucas, HHS inspector general for the Texas region, 10 home health agencies are being actively investigated. The suspected frauds average about $2 million.[83]

- Gordon Barker of Michigan was indicted on nine counts of mail fraud, money laundering, and conspiracy in what prosecutors said was $3.4 million in false Medicare claims involving a home-care agency that Barker ran. According to the indictment, "Barker sought reimbursement for physicians' services when no physicians were on staff."[84]

- "In Louisiana, Linda Faye Jenkins, Patricia May Sanders and four other people pleaded guilty and are awaiting sentencing on charges that they funneled Medicare and Medicaid money from a home health agency into dummy companies."[85]

- In Minnesota, speech therapist Gary Lee Huff, pleaded guilty to mail fraud involving fraud against Medicare and Medicaid and was sentenced to 16 months of incarceration. He contracted with a therapy company to bill Medicare and Medicaid for his work in several nursing homes. Investigators say that on at least two occasions, Huff billed for nearly 20 hours of speech therapy per day with nursing home patients. On another occasion, he billed for using flash cards with a blind patient. He also claimed to have provided speech therapy to a patient several days

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80 *Ibid.*, p. 17.
81 Vilbig, Peter.
82 *Idem.*
83 *Idem.*
84 *Idem.*
85 *Idem.*

after the patient's death and to nursing home residents he never met. He was ordered to pay restitution of $10,000 and a fine of $25,000. "'In reality, this guy was going there and having lunch with the nurses,' said Mike Dyer, regional inspector general for the midwest region."[86]

- "In California, investigators believe a hospice company that cares for the terminally ill may have billed for patients who had already died."[87]

- "The husband and wife owners of two home health agencies in Texas were ordered to repay $180,770 for defrauding Medicare by switching patients between the two agencies to increase reimbursement. The agencies operated out of the same location, employed the same nurses, and served the same patients. They frequently switched patients about every 60 days to obtain the higher number of visits permissible in billing for 'new' patients. Agency employees also altered dates and misrepresented patient medical conditions in nurses' notes."[88]

- "In Indiana, a registered nurse was sentenced to 10 months home detention, 4 years probation and 192 hours of community service, and ordered to pay $10,000 restitution for submitting false reports of skilled nursing visits to the home health agency for which she worked. The result was that the agency submitted the reports to Medicare, which then over reimbursed about $100,000. Noting that the nurse had been convicted in 1975 of mail fraud and in 1993 of theft from patients' homes, the judge ordered her not be involved in any home-bound nursing care."[89]

PRESCRIPTION MARKETING SCHEMES

When the deciding factor for the physician becomes which drug offers the greatest financial reward rather than the patients' well-being and comfort, not only are the health-care needs of patients underserved, the costs of government programs and private health insurance programs are unnecessarily inflated. "Allowing pharmaceutical manufacturers to offer incentives for the prescription of their products can skew physicians' judgment in breach of their fiduciary and ethical duties to their patients. The interest of the patient can become subservient to the physician's financial interest and more effective or less expensive drug equivalents are overlooked in order for the physicians to qualify for the incentives...".[90]

- In Michigan, large quantities of sample and expired drugs were dispensed to nursing home patients and pharmacy customers without their knowledge. When complaints were received from nursing home staff and patients' relatives regarding the

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[86] *Idem*; HHS, OIG, *Semiannual Report*, October 1, 1993 - March 31, 1994, p. 9.
[87] *Idem*.
[88] HHS, OIG, *Semiannual Report*, October 1, 1993 - March 31, 1994, p. 8.
[89] HHS, OIG, *Semiannual Report*, October 1, 1994 - March 31, 1995, p. 11.
[90] Statement of Gerald M. Stern, pp. 2-3.

ineffectiveness of the medications, one of the scam artists stated, "those people are old, they'll never know the difference and they'll be dead soon anyway."[91]

- In 1993, the Department of Justice "successfully pursued [a] case involving improper marketing of pharmaceuticals, in this case Ayerst Laboratories' 'frequent-flier' marketing program for physicians who marketed the drug Inderal LA.... Ayerst enrolled 20,000 physicians in the 'Patient Profile Program.' This program awarded doctors points toward airline certificates or other honoraria each time the doctor placed a new patient on Inderal LA and completed a brief survey."[92]

- "A pharmaceutical company agreed to pay $450,000 in settlement of civil and administrative claims that it defrauded Medicare. The company created a 'grant-in-aid' research program which offered physicians kickbacks in the form of grants in exchange for performing small-scale studies of its antibiotic. From 1986 to 1991, the physicians were paid fees of $500 to $2,500 to treat patients with the company's antibiotic. Investigation showed that in most cases the research performed by the physicians was not of scientific value. In addition, some physicians never completed the research but received full payment from the pharmaceutical company."[93]

FALSE, UNNECESSARY, AND NONEXISTENT LABORATORY TESTS

Medicare, Medicaid, state health programs, and private health insurers have experienced increased costs because of the widespread use of marginally necessary or totally unnecessary laboratory tests and procedures.

- "Billing for useless laboratory tests and cheating both government and private insurers is still occurring. In Maryland, a laboratory and its owner were found guilty of numerous counts of fraud and theft. The defendants were charged with billing government and private insurers for performing more than 8,000 unauthorized and useless diagnostic tests totaling nearly $150,000. The owner was also convicted of representing a laboratory which was in violation of the state's quality assurance laws. He was sentenced to serve five years and ordered to pay $161,000 to Medicaid, Medicare and several commercial health insurance companies."[94]

- "The owner of a DME company in New York was sentenced to five months in jail for Medicare fraud and ordered to pay $100,000 in restitution for falsifying blood tests to justify claims for oxygen equipment and inflating hours of oxygen use to obtain higher reimbursements."[95]

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[91] *Gaming the Health Care System*, p. 2.
[92] Statement of Gerald M. Stern, p. 3.
[93] HHS, OIG, *Semiannual Report*, October 1, 1994 - March 31, 1995, p. 19.
[94] Testimony of Thomas Temmerman, director, Bureau of Medical Fraud, before the Senate Special Committee on Aging, March 21, 1995, p. 4.
[95] *Gaming the Health Care System*, p. 6.

- In one of the largest health-care fraud cases in U.S. history, National Health Laboratories Inc. of San Diego, California, agreed to repay $110 million for false claims it had submitted to Medicaid and Medicare. "The company had induced doctors to order lab tests which were medically unnecessary by assuring the doctors the tests would be free or of nominal charge. In fact, the company was billing government insurers for the tests without the referring physicians' knowledge."[96] In defending themselves, employees of National Health Laboratories contended that overcharging was common in the industry, investigators said."[97]

- A man was sentenced in California to more than four years in prison, ordered to pay $895,373 in restitution, and fined $450 for submitting false Medicare claims. "He received almost $1 million by using various physicians' provider numbers to bill for blood circulation tests he never performed. He diverted notices of payment to 38 mail drops he controlled by putting false beneficiary addresses on claims. He attempted to avoid arrest by using stolen license plates on his car and an assumed identity, but was arrested when he purchased $250,000 in gold bullion and coins. Another $325,000 in California and Florida bank accounts was also seized."[98]

- "A Florida osteopath and his wife were excluded from the Medicare and state health care programs for 10 years because of conviction for obstruction of justice and filing more than $800,000 in fraudulent Medicare and private insurance claims. The pair filed claims for medically unnecessary or non-performed tests, much of them for services supposedly performed for the wife's parents. The osteopath used an independent laboratory for the tests but filed claims indicating the services were rendered in his office, in order to obtain higher reimbursement. He tried to conceal the fraud by presenting falsified documents to a grand jury.... Both the osteopath and his wife received prison sentences and were ordered to make restitution of $584,500."[99]

- "Two medical groups associated with a Washington state hospital agreed to pay the government $850,000 in settlement of allegations that they submitted inflated Medicare claims for laboratory services. Investigation showed that thousands of profile tests ordered by physicians were split, or 'unbundled,' into components which were then billed individually to Medicare. In this way they received a higher reimbursement."[100]

- "In Texas, a laboratory owner was sentenced to 3 months in prison, followed by 90 days in home confinement and 3 years supervised probation for fraudulent Medicare billing. The man operated a mobile clinic which offered free screenings for senior

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[96] Cohn, Gary, "Health Care Fraud Gets More Scrutiny," *The Baltimore Sun*, December 4, 1993, p. 3C.
[97] New York Times News Service, "5 Top Medical Labs' Records Subpoenaed in U.S. Billing Probe: Medicare, Medicaid Focus of Investigation," *The Baltimore Sun*, August 28, 1993, p. 15C.
[98] HHS, OIG, *Semiannual Report*, April 1, 1993 - September 30, 1993, p. 18.
[99] *Ibid.*, p. 21.
[100] *Ibid.*, p. 23.

citizens. He or one of his employees would obtain their Medicare numbers and bill the program for unnecessary tests or tests not performed."[101]

- "In Ohio, a physician was sentenced on the basis of a negotiated plea whereby he had agreed to cooperate with the government in exchange for dismissal of charges under pretrial diversions for his sister/employee, and for his corporation. During a 4-year period, he billed Medicare more than $1.5 million and was paid $560,000, over 60 percent of which was for laboratory services supposedly performed in-house. A carrier utilization review showed he billed as much as 600 percent more than his peers in some areas. He was accused of billing Medicare, the Civilian Health Medical Program of the Uniformed Services, and private insurers for laboratory services not performed or not medically necessary, double billing and money laundering."[102]

MEDICAL BILLING COMPANIES BILKING THE TAXPAYER

Setting up a Medicare billing company is an easy way to scam the program. According to a Knight-Ridder article, "Scamsters used rented mailboxes and beepers as business phones. They billed Medicare with the stolen names and Social Security numbers of Medicare patients."[103] The newspaper uncovered a half-dozen phony companies that had submitted fraudulent billings, including one that listed a golf course sand trap as its address. The same article noted that it was easy to fill out a four-page form that asks for a name, address, phone number, and a statement saying the operator hasn't been in trouble with Medicare before. Most of the time, Medicare never checked the information.[104] Once the billing company is set up, the flood gates of fraud are open.

- In Dade County, Florida, alone, 500 phantom companies tried to bill Medicare in the space of two months during 1994 "and many of them got away with $6.7 million before the government stopped mailing them checks.... Most of the companies didn't even have telephones and operated out of mail drops.... [A] company which collected $100,000 from Medicare stated in billings that some of its patients lived in a vacant south Dade warehouse."[105]

- "The Florida Medicare carrier agreed to pay the government $10 million to settle allegations that the company mishandled and caused massive backlogs in Medicare claims, submitted false claims and increased costs to Medicare. In December, 1988, the company, the second largest Medicare processor in the nation, switched to a new computer system to process Medicare Part B claims. Beginning in early 1989, computer deficiencies created a backlog of payments for these claims. In an effort to reduce the backlog, the company bypassed computer audits and edits, created false

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101 HHS, OIG, *Semiannual Report*, October 1, 1994 - March 31, 1995, p. 9.
102 *Ibid.*, p. 10.
103 Dubocq, Tom, "Medicare, citing fraud, plans to scrutinize billing companies," some operating out of mail drops, bilked agency out of millions," *The Fresno Bee*, September 2, 1994, p. C18.
104 *Idem.*
105 *Idem.*

prescriptions and paid duplicate claims to providers, thereby increasing administrative costs for the program."[106]

- "The former chief financial officer of a New Jersey medical center was excluded for 25 years for conviction of mail fraud and conspiracy that included Medicare and Medicaid fraud. The officer was part of a network of conspirators who diverted checks made out to the hospital, overbilled for collection notices sent overdue accounts, processed invoices for goods never delivered, and paid and accepted kickbacks. The officer filed false tax returns, failing to list fraudulent funds received. Total financial damages from the conspiracy amounted to an estimated $2.5 million."[107]

- "The Florida peer review organization (PRO) signed a court-ordered civil settlement for $1 million for approving and backdating hospital payments, without required reviews, on claims previously denied. More than a year ago, the PRO pled guilty to related criminal charges, its contract with HCFA was prematurely terminated and almost $2 million of the approved overpayments was withheld. The civil case was initiated by former PRO employees. Of the $1 million settlement, $680,000 will be used to pay amounts owed to the Internal Revenue Service, the employees pension fund, and unpaid benefits due employees and former employees. Another $320,000 is to be applied toward directly related false claims."[108]

- "In Virginia, the twelfth and final person was sentenced in a scheme in which Traveler's Insurance employees issued Medicare checks to friends who forged and cashed them. The woman was sentenced to 4 months home confinement and 3 years probation. She was ordered to pay a $2,000 fine, a $150 special assessment and restitution of $11,101 for the two Medicare checks she cashed. Those previously sentenced in the case included two Traveler's employees, a top manager of an international beverage company, a former deputy sheriff and the chief buyer for a drug store chain. The embezzlement involved 56 Medicare checks totaling $250,000."[109]

- "A Massachusetts carrier paid $2.75 million to settle a qui tam suit initiated by a former employee. The settlement was based upon submission of false Medicare reports for Massachusetts, Maine, New Hampshire and Vermont. The carrier misrepresented and inflated the number of claims and reviews it processed in periodic reports submitted to HCFA. The carrier also received larger reimbursements from Medicare as a result of the false data submitted."[110]

TAKING TAXPAYERS FOR A RIDE: AMBULANCE AND TAXI SERVICES

106 HHS, OIG, *Semiannual Report*, April 1, 1993 - September 30, 1993, p. 22.
107 *Ibid.*, p. 20.
108 *Ibid.*, p. 23.
109 HHS, OIG, *Semiannual Report*, October 1, 1994 - March 31, 1995, p. 11.
110 *Ibid.*, pp. 16-17.

- Over 16 months, on behalf of one beneficiary, a wheelchair van service billed Medicare for $62,000 or approximately one trip every two days at an average of $260 per trip.[111]

- A now-defunct San Jose ambulance company, Medicar, routinely billed Medicare for transportation charges from $250 to $450. In one instance, a patient was taken by ambulance from a convalescent hospital to a hospital directly across the street. In some cases, "Medicare provided service equivalent to a taxicab ride."[112]

- "The owner of an Indiana ambulance company was sentenced to 41 months in prison and 3 years probation for defrauding Medicare, Medicaid and Social Security programs as well as private insurers. He filed claims amounting to more than $200,000 for transporting stretcher cases, when most of the patients his company transported were ambulatory or in wheel chairs. Many of his company's records, obtained by search warrant, contained 'Post-It' notes from him to a clerk to 'bill this to Medicare because I need the money.' Also discovered during the investigation was the fact that he had been fraudulently receiving Social Security disability benefits for 10 years while employed and operating a business."[113]

- "An ambulance company signed a civil settlement with the United States and the state of Minnesota agreeing to pay $3 million for filing false Medicare and Medicaid claims. The company also agreed to provide $97,542 in free ambulance services to financially eligible consumers in Minnesota. The company was overpaid more than $1.17 million by Medicare and Medicaid as a result of false billings."[114]

- "The former owner of an Oklahoma ambulance company was sentenced to a year and a day in federal prison and 2 years supervised probation for Medicare and Medicaid fraud. Over a two-year period, the woman and her husband defrauded the programs of $370,000 in false billings. They submitted bills for ambulance trips for dialysis patients that they claimed were not ambulatory, but surveillance cameras caught several of the patients walking to and from the ambulances with little or no assistance.... The ambulance company has gone out of business."[115]

SELLING TAINTED MEDICAL SUPPLIES: THE FOX IN THE HEN HOUSE

- An Indiana man was sentenced to six years in prison for mail fraud, illegal possession of a document-making implement and tampering with heart pacemakers he sold to hospitals. "The man sold DME in at least nine states under 34 aliases and 11 different

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111 GAO, *Medicare, Modern Management Strategies,* p. 6.

112 Williams, Isabel, "Defunct San Jose Firm Accused of Fraud in Ambulance Scheme/$1.7 million of unnecessary services," *The San Francisco Chronicle,* November 12, 1994, p. A6.

113 HHS, OIG, *Semiannual Report*, October 1, 1993 - March 31, 1994, p. 8.

114 HHS, OIG, *Semiannual Report*, April 1, 1993 - September 30, 1993, p. 22.

115 HHS, OIG, *Semiannual Report*, October 1, 1994 - March 31, 1995, p. 9.

corporate names. Seven of his employees were also sentenced on charges related to the unlawful sale of pacemakers, impeding the ability of the Food and Drug Administration to regulate the medical device industry, offering gratuities to physicians, and committing mail fraud against hospitals. Because of the pacemaker tampering, during the investigation, federal authorities issued advisories to physicians receiving the devices warning of facts uncovered, including expiration dates lapsing before devices were implanted, improper sterilization, recycling of pacemakers, and mislabeling of pacemakers intended for animal use only. The owner also was given a 20-year exclusion from Medicare and Medicaid which cannot be appealed, and was ordered to never again operate a medical device company. A physician who did business with the man was also sentenced, and other sentencings are expected."[116]

- "Georgetown University Hospital has agreed to pay the U.S. government more than $2.5 million for failing to refund Medicare overpayments, and several other District hospitals are being investigated for health care fraud, U.S. Attorney Eric Holder said.... The investigation into the hospital's handling of Medicare credits began after an audit of the hospital's patient accounts department revealed that the hospital was 'zeroing out' Medicare credit balances. A subsequent audit established that this practices resulted in GUH improperly retaining over $1 million of federal Medicare funds, the U.S. Attorney's office said."[117]

- "The owner of a Silver Spring eye surgery center has agreed to pay $750,000 in restitution and penalties to settle federal charges he submitted false Medicare claims.... The payment by the ophthalmologist, Seymour J. Dubroff, is the result of a 1 1/2-year investigation by Health and Human Services. He was accused of submitting to Medicare $180,000 in bills for eye surgery that in some cases was not performed and in others was not reimbursable under federal rules. Under the agreement, the federal agency will not try to bar him from participating in Medicare.... The government said it found fraud in 185 bills submitted on behalf of his patients between 1986 and 1990. The case began with a tip from one of Dr. Dubroff's patients who had received a statement from Medicare that showed excess payments."[118]

EMBEZZLEMENT OF MEDICARE FUNDS

Embezzlement, a common white collar crime, is penetrating the Medicare system. For example:

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[116] HHS, OIG, *Semiannual Report*, April 1, 1993 - September 30, 1993, p. 17.
[117] Metzler, Kristan, "Georgetown U. Hospital To Repay Medicare Money," *The Washington Times*, December 24, 1993, p. C4.
[118] Meisol, Patricia, "Surgeon Settles Claim," *The Baltimore Sun*, June 1, 1993, p. 1B.

- A person "was sentenced for participating in an embezzlement scheme perpetrated by former employees of the Virginia Medicare carrier that netted an estimated $100,000. The employee, including the supervisor of a special carrier project in which Medicare beneficiaries were paid by manually drawn checks, wrote checks which friends forged, cashed and gave back 50 percent of the proceeds. A woman who admitted cashing 17 checks was sentenced to 12 months incarceration and ordered to repay more than $70,150."[119]

- "A former employee of the Rhode Island Medicare carrier was sentenced for embezzling more than $30,000 from the program. Her duties included microfilming undeliverable reimbursement checks. After beneficiaries complained about not receiving checks, investigators showed that she had embezzled 44 checks over a 5-month period and cashed them at local banks for her own use."[120]

- "A former hospital official in Pennsylvania and several others were convicted of embezzling Medicare and [Department of Health and Human Services] block grant funds paid to the hospital. After his release from prison, the former official received $128,000 from a life insurance policy but made no payment on a fine of $23,350 and restitution of $159,570, as he had been ordered. Instead, he distributed the money to friends and relatives, and attempted to keep the money secret from the probation department. He was told by the court to pay the fine immediately and submit a plan for restitution, or he would have to return to prison for 6 to 9 months."[121]

CONCLUSION

If Medicare's centralized, non-competitive, single-payer system is at the heart of billions of dollars in wasted resources, eliminating waste, fraud, and abuse requires that competitive market forces be introduced into the Medicare system. Free market forces and incentives would reduce Medicare's excessive costs and improve the quality of health care for seniors. Moreover, we would finally provide seniors with a medical system that develops greater quality rather than a system that increasingly consumes more and more health dollars.

The following specific recommendations are crucial to ensure that Medicare is protected, preserved, and strengthened:

1) Increase Medicare's anti-fraud and abuse efforts and prosecute Medicare fraud more vigorously;

2) Establish a national health-care fraud data base that includes information on final adverse actions taken against health-care providers;

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[119] HHS, OIG, *Semiannual Report*, October 1, 1993 - March 31, 1994, p. 18.
[120] *Idem.*
[121] *Idem.*

3) Take steps to protect Medicare better from fraudulent provider billing practices, such as revise and strengthen national standards that suppliers and other providers must meet in order to renew a Medicare provider number, prohibit Medicare from issuing more than one provider billing number to an individual or entity, require Medicare to establish more uniform national coverage and utilization policies for what is reimbursed under Medicare, and require HCFA to review and revise its billing codes for supplies, equipment, and services in order to update, clarify, and standardize billing codes;

4) Enact legislation to assure HCFA can adequately and consistently fund contractors' safeguard activities;

5) Improve coordination between federal and state agencies to track, investigate, and prosecute Medicare fraud;

6) Require providers to demonstrate their suitability as Medicare vendors before giving them unrestricted billing rights;

7) Allow Medicare to price services and procedures more competitively;

8) Require HCFA to assume a more active management posture over contractors' program operations; and

9) Streamline whistle blower procedures to ensure that seniors can report incidents of fraud more easily, and provide incentives/awards to do so.

Statement of
June Gibbs Brown, Inspector General
Department of Health and Human Services

I appreciate the opportunity to comment on H.R. 2326 and H.R. 1850. These bills enhance and strengthen many of the enforcement tools in the Inspector General's arsenal for combatting fraud and abuse--a problem which squanders our limited governmental resources and which can adversely affect our program beneficiaries. At a time when various health care cost savings are being considered by the Congress, efforts to control fraud and abuse are highly appropriate, helping our federally funded health care programs to operate efficiently, economically and effectively.

Coordination and Resources

We strongly endorse the proposals in H.R. 2326 and 1850 to establish a new and comprehensive fraud and abuse control program applicable to all payers. Such a program would strengthen the current efforts of Federal and State governments, as well as private third party payers, to coordinate their enforcement efforts. Ten years ago, the Office of Inspector General (OIG) helped establish the National Health Care Anti-Fraud Association (representing both governmental and private third party payers and law enforcement agencies) to coordinate governmental and private health care fraud enforcement activities. Over the years, this governmental/private partnership group has been extremely successful in fostering collaboration.

Moreover, the OIG has recently established with the Department of Justice and other enforcement agencies an Executive Level Working Group to focus on health care fraud, and we have started to see positive results. However, better communication and coordination of law enforcement activities are clearly needed in the fight against health care fraud and abuse, and your proposed all-payer fraud and abuse control program would foster such activities.

The proposals in H.R. 2326 and H.R. 1850 to establish a Health Care Fraud and Abuse Control Account would also improve our enforcement efforts significantly. We support a mechanism whereby funding to combat fraud and abuse is increased without drawing down from the U.S. Treasury, or burdening taxpayers further. Under the approach suggested in both of these bills, financial recoveries derived from health care fraud cases such as criminal fines, civil penalties and damages under the False Claims Act, and administrative penalties and assessments, would be deposited into an account, to be made available for the future funding of fraud and abuse enforcement activities. This plan makes the individuals who actually perpetrate fraud against, or otherwise abuse our Federal programs, pay the costs of increased enforcement in those programs. We would recommend that the legislation ensure full restitution to government health care programs of monies lost due to fraud, as well as investigative costs incurred by the OIG, before any funds are to be deposited into the account.

Legal Remedies

H.R. 2326 contains several proposals for expanding current criminal, civil and administrative authorities of the OIG. We applaud these efforts to strengthen available legal remedies, which assist us in targeting wrongdoers and provide increased deterrence as well. We are especially interested in

your proposals for enhancing the remedies available to the OIG under the Civil Monetary Penalties Law (CMPL) and the permissive exclusion provisions of the Social Security Act. The CMPL, section 1128A of the Social Security Act, was enacted in 1981 as an alternative administrative remedy to civil prosecution under the False Claims Act. It provides a means to administratively impose civil monetary penalties and assessments, and exclusions from program participation, on individuals and entities who submit false or improper claims for payment to Medicare, Medicaid and the other State health care programs. The permissive exclusion authorities for sanctioning aberrant health care providers, set forth at section 1128(b) of the Social Security Act, allow for the exclusion of individuals or entities from program participation if, under certain criteria, the OIG determines an exclusion to be warranted. Permissive exclusions may be taken based on convictions for non-Medicare/Medicaid health care fraud, State licensing suspensions and revocations, or controlled substance violations.

Amendments to the OIG's CMPL Authorities

We strongly support your proposal to expand the OIG's Civil Monetary Penalty authority to impose strict liability upon employers who hire and bill for the services of individuals who have been excluded from participation in government health care programs. Currently, the CMPL holds an excluded provider strictly liable (i.e., liable without proof of knowledge or intent) for claims submitted, or caused to be submitted, for services that he or she renders while excluded. However, some excluded individuals have continued to treat program beneficiaries, and have improperly caused the Medicare and Medicaid programs to pay for their services, by seeking employment with participating providers who agree to bill for their services. Expanding application of the strict liability standard to the employers of excluded providers will enhance our ability to protect program beneficiaries, while protecting the financial integrity of the programs themselves. Such a provision also encourages health care employers to ascertain the program participation status of employees prior to submitting claims for payment for services rendered, ordered, or directed by such individuals.

An additional amendment to the CMPL that would significantly enhance our enforcement authority would be to expand the reach of the CMPL to include all Federal health care programs. Currently, the CMPL only reaches those who submit or cause the submission of claims to one of four Federal programs: Medicare Medicaid, the Maternal and Child Services Block Grant program, and the Social Services Block Grant program. Thus, under current law, the OIG cannot impose civil monetary penalties and assessments against, for example, someone who submits false claims to the CHAMPUS program or the Federal Employees Health Benefits Program. Modifying the CMPL to apply to health care providers who defraud other Federal health care programs would enable the Government to protect additional beneficiaries from harm, and additional Federal programs from financial loss.

Another modification to the CMPL that would greatly aid our enforcement efforts is extension of the CMPL's strict liability standard to excluded providers who order or prescribe items or services for program beneficiaries, even if they directly furnish no services to beneficiaries. Currently, excluded providers who submit or cause the submission of claims for services furnished during their exclusion periods are strictly liable for those claims. However, we have seen egregious cases of excluded individuals who continue to profit from the Medicare and Medicaid programs by ordering or prescribing items or services from others, such as lab work or pharmaceuticals. Expanding the

CMPL's strict liability standard to excluded providers who do not personally render or direct the provision of health care to program beneficiaries, but who order or prescribe items or services on their behalf, would help the OIG curtail the continuous fraud committed by certain providers. In addition, such a provision will encourage ancillary care providers and suppliers (such as laboratories and pharmacies) to check out providers who refer business to them and to refuse to deal with those who have been excluded from the health care programs.

Amendments to the OIG's Permissive Exclusion Authorities

The OIG's exclusion authorities are an important enforcement remedy. We have made great strides, not only in excluding aberrant providers from our programs, but also in ensuring that they don't continue to abuse our health care financing systems and our beneficiaries. However, there are still some loopholes that allow fraud and abuse to thrive at the expense of the programs, the taxpayers, and program beneficiaries.

The proposal in H.R. 2326 to impose a new permissive exclusion authority against individuals who own or control sanctioned entities closes one such loophole. This new authority would enable the OIG to exclude individuals who own or control entities that have been convicted of program-related crimes, entities against which penalties have been imposed under the CMPL, and entities that have been excluded from Medicare and State health care programs. We have found that unscrupulous health care company owners simply change corporate structures or move from one business to another if the first has been convicted or excluded. As our authority now stands, if an owner is convicted and excluded, then we can exclude any company associated with that individual. However, if a company is excluded, we currently have no authority under which we can take action against the owner of the company. That individual is free to reincorporate or start another business with no fear of exclusion. Your proposal permits the OIG to exclude culpable individuals who move from company to company, shutting the door on these "mobile" business owners.

Additional Anti-Fraud Initiatives

We applaud the proposal in H.R. 2326 to require carriers and fiscal intermediaries to reimburse the Medicare Trust Funds for any health care program funds paid to excluded providers once the carrier or intermediary has been notified of the exclusion. If these contractors fail to take the administrative steps necessary to implement and enforce the OIG's exclusions, they should remain liable for any claims wrongfully paid to an excluded party. By preventing improper disbursements of program funds to individuals and entities not entitled to receive them, this provision should result in substantial savings to the Federal health care programs. However, we recommend that this provision be expanded to impose the same liability upon States that fail to implement the OIG's exclusions. We have had experiences with State Medicaid agencies which have neglected to enforce OIG exclusions in a timely and proper manner. The lesson of these experiences is that a mechanism is needed to ensure that the States respond to the OIG's exclusion notices. Expansion of your legislative proposal affecting carriers and fiscal intermediaries to State Agencies that fail to implement OIG exclusions would provide such a mechanism.

Again, we appreciate having an opportunity to comment on this legislation and will be happy to continue working with your staff on these important issues.

Mr. SHAYS. My staff tells me that much of what's in that book deals with the whole market pricing issue, a good amount of it. So while we focused a lot on the issue of criminal law, the market pricing issue, to me, is just getting reinforced, evidently, in that book.

Mr. Schiff, we will start with you.

Mr. SCHIFF. Thank you, Mr. Chairman. Mr. Chairman, I'm going to be brief, because I think the witnesses' testimony stands for itself. But I want to make a point that you were getting at a moment ago.

We have several factors converging at once. The first is, we know that Medicare is going to be addressed immediately, in some fashion, in legislation, because it has to be. That's not actually advocating one side's policy versus another but recognizing it has to be addressed.

Second, we know that health care fraud has to be addressed at the same time, and that is the present plan in the Budget Reconciliation Act.

By the way, I drafted this legislation with Congressman Shays, broadly, for all health care. It was suggested that it was overly broad; the U.S. attorneys will never get to every case. That may be true, but why should we limit where the U.S. attorneys can pick and choose. Because someone who is defrauding the Government program is defrauding the private programs, and vice versa. So why not have the broad range of options to Federal prosecutors?

The point I want to make is that—and there is a great deal of haste now. There's a great deal of provisions in the Budget Reconciliation Act, some of which are contentious, some of which aren't. But there's a lot of competition now for the attention of the Ways and Means Committee staff members and the congressional Members.

Here is the point I want to make: I would be very grateful, and I think it's appropriate, if each of your three organizations would get in on this right now. I mean, right after lunch wouldn't be too soon, I can tell you that. The fact of the matter is, I am concerned that just because of the press of other business, the Ways and Means Committee may stand on H.R. 2389. And there is a lot in H.R. 2389 that I agree with. There are a couple points that I would question. Similarly, there are some questions about H.R. 2326.

Here is the point where it's not a matter of pride of authorship; it's a matter of using the Budget Reconciliation Act to achieve our common goal. What I would ask the three of you to do, through your organizations, is, through whatever contacts you have with Ways and Means Committee members or staff, to immediately bring to their attention that there is also H.R. 2326, there is also H.R. 1850, I believe, Congressman Towns' bill.

These include provisions that we know are not in H.R. 2389. The health care fraud criminal statute is one. The single provider identification number is another. And say, "Look at this. All of these ideas can be integrated into one enlarged portion of anti-fraud." H.R. 2326 largely does not conflict with H.R. 2389. You could put them together in one bill right now and have very little, if any, conflict.

But we need your help. If we're going to get in this legislation, instead of waiting until a year from now or 10 years from now, we're going to need everyone who is interested in this subject to get the attention of the Ways and Means Committee right at this moment. So that's what I would be grateful from all three of your groups.

With that, I thank the witnesses for their testimony and yield back, Mr. Chairman.

Mr. SHAYS. I thank the gentleman.

Mr. Towns.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Let me, I guess, ask, "in your opinion," because of the type of question that it is. Of course, you know, in terms of Medicaid, in particular, that the States will be receiving a lump sum to carry out obligations and responsibilities. Being that they will have a lump sum, and of course this lump sum will be less than what they are getting now, do you think that, as a result of States trying to meet their health care needs, they just might forget about law enforcement?

Mr. SCHATZ. If I could address that first, Mr. Towns.

Mr. TOWNS. Sure.

Mr. SCHATZ. It seems to me that they would have more incentive to detect and prosecute fraud because of the fact that they are getting less money. They have to provide more with really less, if you look at it. The point of working, I think, through a lot of these programs, overall, in this Congress, is that the money that reaches the beneficiaries, at this time, goes through lots of layers, through the Federal and State Governments, until it really reaches the people it needs to reach.

One of the things that I believe the leadership, and there is, in fact, a lot of bipartisanship over this, providing the States with the money, is to give them both the responsibility and the incentive to use that money more efficiently than it's being used right now. And I would certainly hope, in your role as the oversight subcommittee on these issues, that you would make sure that that is being done. Because certainly, if they are throwing the money away and they come back here and ask for more, it's not going to happen under the current budgetary scheme.

I can't guarantee it; I just think, honestly, that's what's going to happen.

Mr. TOWNS. Yes. Mr. Mahon.

Mr. MAHON. I think it's too soon to know all the implications or the repercussions of it, Mr. Towns. But I certainly hope they would adopt the point of view that Mr. Schatz outlined; that is, that they need to safeguard as much as they can of every dollar they are getting in these block grants.

Most of the States have existing Medicaid fraud control units in place, so you would think and hope that they would simply keep those units in place and have to restructure the flow of money into those units. Rather than shared by Federal and State, presumably, they would be funded by the State out of the block grant.

The only reason I'm not certain that would happen is because we have examples, at the Federal level, of the HHS IG's investigations budget being cut year after year, so there is certainly precedent in

Government for cutting the anti-fraud resources along with other measures and programs that are designed to achieve economy. In the case of anti-fraud, we certainly think that's a false economy.

Mr. TOWNS. Thank you very much, Mr. Mahon.

Ms. Burgess.

Ms. BURGESS. Mr. Towns, I think it's going to depend a great deal on the State as to how it's approached. I have gone back on the Medicaid Advisory Committee in New Mexico because I've been very much concerned with the block grants, very much concerned. We're a poor State, and I'm very concerned as to what will happen.

I certainly am going to take all of this back to that committee, and certainly there will be a great deal of urging. Many of us feel strongly that this must be dealt with, that it's very, very important, and we will do the best we can within the State to see that it is properly looked at. I don't know what will happen, frankly.

Mr. TOWNS. Mr. Mahon, will the all-payer approach we propose to adopt lead to private payer assets being deposited into the health care fraud control account? If so, is the Government entitled to these funds, in your opinion?

Mr. MAHON. No, I would hope not, Mr. Towns. One of the points we made in our statement is the importance of giving the private payers some reasonable shot at restitution in cases that they refer criminally. Years ago, the problem was getting cases investigated criminally, let alone prosecuted and convicted. Given the law enforcement initiatives of recent years, the problems now tend to occur somewhat further down the line, often in the sentencing phase, when it comes to restitution. It's something that isn't taken into account up front.

One of the potential byproducts of setting up the trust accounts, which is a very common feature of anti-fraud bills today and one that I think everyone is pretty much resigned to, is the fact that, in a way, you are putting the law enforcement agencies in competition with the private victims when it comes to the available assets in a given case. I was delighted to see, both in your language and in H.R. 2326, the notation that funds were to be other than restitution.

The question you asked Mr. Stern earlier about ERISA plans' assets being deposited, from our perspective, the fundamental point in incorporating or including the Labor Department IG is that, absent any direct anti-fraud activity by the agency that has jurisdiction over those self-funded plans, the typical self-insured company plan that also administers its own claims is just as vulnerable to health care fraud as is a commercial insurance company or the Medicare program or a Blue Cross-Blue Shield plan.

So we think, in any coordinated effort, there should be some acknowledgement made of the exposure of the self-funded plans.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Let me thank all of you for your statements and also your answers.

Mr. SHAYS. I thank the gentleman.

Mr. Martini.

Mr. MARTINI. Yes. Thank you, Mr. Chairman.

It's not so much of a question as it is, I guess, an observation and a comment. I first would like to thank the panelists for their

testimony. I obviously feel that the direction of this legislation is certainly in the right direction, the intent of it is.

All too often, from my experience in my prior life as a lawyer and as a former prosecutor, one of the difficulties in this area was impressing upon the various prosecutors' offices the importance of getting involved in this area. So I think this legislation will accomplish at least that. It will now, at least for a while, make them aware that this is an area of concern for the American people.

Also, I think one of the real practical problems often was, from their perspective, having to fit a certain pattern of facts into a particular anti-fraud statute, and most generally it would be the wire fraud or the mail fraud statutes. Sometimes that was difficult to do. So, to the extent this legislation codifies that we're serious in terms of feathering out fraud in the health care area, I think it, one, will certainly do that.

Also, to the extent that this and other legislation defines accurately what is and is not permissible, which is, I think, another factor that has to be taken into account, defining what conduct is permissible and what conduct is not permissible, what conduct is criminal and what conduct is not; in this area, I think that may be the more difficult problem.

What I heard often, in the town hall meetings I had, was conduct which may or may not be criminal, per se. In fact, under the current Medicare system, as I began to view it, we have a system that really does not encourage any of the people involved in the system to save funds or to be efficient in how they use the system. In fact, it almost welcomes and, in fact, encourages the opposite.

It encourages providers, in many instances, to overtreat, overmedicate, or whatever. It encourages beneficiaries, in many instances, to go more often to the doctor than they really have a need to. How we feather that out of this system is really, I think, getting to the heart of it. I think that's more dealt with with the overall Medicare plan, which is introducing the private sector into the plan, which therefore will introduce some incentives to try to keep costs in line.

But, again, let me just close by saying, I think certainly this legislation is meritorious. It's long overdue. As a new Member here, I often would call this a no-brainer. Not to slight anyone, but I'm sitting here wondering why this hasn't been done. I mean, as a layperson out there, for years, we've heard of all the abuses in Medicare and Medicaid, and yet I'm sitting here saying, this is something that should have been done a long time ago.

But I think that's why this committee and the leadership here deserves a lot of compliments for getting this out. I'm certainly hopeful this will be part of the final package and be over with already.

Thank you.

Mr. SHAYS. I thank the gentleman. As it relates to being a no-brainer, this is my one concern.

Mr. MARTINI. No slight, Mr. Chairman.

Mr. SHAYS. No, no, no, no.

Mr. MARTINI. That was a compliment.

Mr. SHAYS. I use that phrase all the time. My concern is that I think some in our own conference think that doctors aren't crooks

and hospitals aren't crooks, and therefore no one should go after them in a criminal way. I think we need to, on our side of the aisle, weigh in on that one.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. I appreciate my colleague from New Jersey discussing the need for lobotomies.

I appreciate the panel being here today. Mr. Schatz, I have read your statement and also skimmed the report. On the first page of your statement, in the last paragraph, you say, "Medicare and its impending bankruptcy are too important to ignore the consequences of a failing to act. Yet those who are fighting any reform claim that each dollar spent in the program produces a dollar in benefits for American seniors; no waste, no fraud, no abuse." Who has said that?

Mr. SCHATZ. Mr. Green, there have been comments made throughout; really, the atmosphere here in Washington that maybe no changes need to be made to Medicare, or Medicare can survive without changes.

Mr. GREEN. OK. Now, you say, no waste, no fraud, or abuse. I want to know if anybody, on the Republican side or Democratic side, said there was no waste, fraud, or abuse.

Mr. SCHATZ. Well, it was really just a statement, saying that as a way of characterizing people. I'm not saying anyone specifically said that. I didn't quote anyone.

Mr. GREEN. OK. Now, we'll get to what I'm concerned about. OK. You also talk about, on page 5, "commends the majority leadership in the House for 'The Medicare Preservation Act.'" Do you think those of us who are cosponsors of this bill, one of the bills here today, if we don't vote for the Medicare Preservation Act, that we're for waste, fraud, and abuse?

Mr. SCHATZ. Absolutely not, Mr. Green. Mr. Towns' bill, I have already complimented him on his bill. I believe it's very important.

Mr. SHAYS. He was almost fawning.

Mr. SCHATZ. The only difference really is the criminalization of the health care aspect.

Mr. GREEN. I agree. In fact, I've never served in a prosecuting office, but I know we need to provide that ability. I guess what worries me, I want to know if anybody is supporting waste, fraud, and abuse or saying there is none, even though we may have a philosophical difference on the Preservation Act or the impending bankruptcy in the year 2002.

And I guess I relate it to, if we don't put any money into Medicare, by 2002 it will be bankrupt, but if I don't put any money in the Department of Defense tomorrow, they will be bankrupt. Is that correct?

Mr. SCHATZ. Well, Mr. Green, this is now the, I believe, ninth time the trustees have reported that Medicare will be bankrupt. Next year, however, is the first time we will actually see red ink. So I think it is clearly more serious than we have seen in the past.

Mr. GREEN. They have always given a deadline, though, in the other eight times.

Mr. SCHATZ. Excuse me.

Mr. GREEN. They have said, if Congress does not do something in this year, it's 2002.

Mr. SCHATZ. That's correct.

Mr. GREEN. You know, 15 years ago, it was some other date.

Mr. SCHATZ. Well, let's look at just the example of Social Security, where, in 1982, they were supposed to fix it for the next 75 years. Of course, that's not the case either. One of the things, clearly, that, if you're talking about Medicare reform overall, needs to be looked at—I'm a baby boomer; I think many of the new Members are in the same category—they are not even looking at what is going to happen when the baby boomers retire.

So, in the context of overall Medicare reform, if you're talking 90, 270, a trillion in changes, there's a big red ink line going far into the future on Medicare itself.

Mr. GREEN. You're right, and we have to do something to address it. I guess the concern I have is that I am a cosponsor of our chairman's bill, and in reading your testimony and looking at it, it almost—if you don't necessarily agree with the Preservation Act, then you're for waste, fraud, and abuse. And that's not what this committee is about. I think you're going to see bipartisan support.

Mr. SCHATZ. Let me state under oath, which I am, that that is not what I was intending to say. It is not what I am saying right now. And I certainly agree that, in this instance, the bipartisanship on this issue is extremely, extremely important.

Mr. GREEN. Again, on your first page, going to the report, again, I think you've documented a lot of the problems that we see and we hear from our constituents, and I hear every day, and we try to deal with. I am frustrated with the bureaucracy, or whatever the system, for not being able to deal with it.

During this year, the budget we passed here, under HHS there was actually a small cut in the effort to root out fraud, waste, and abuse. There was no growth at all, but there was a small cut; not dramatic, but a small cut. So that's obviously not the way we need to go. I want more investigators, more people auditing.

Mr. SCHATZ. The Citizens Against Government Waste was created following the Grace Commission report. Many of the recommendations dealt with management improvement. Just as we are now finding, in terms of "scoring," we know, and I believe Mr. Kusserow, when he testified at our hearing, said, I think it was, either $68 or $86 gets turned back in for every $1 you put into investigations.

I don't care what CBO says, we know, and I'm sure everybody on this panel knows, that you can get an awful lot of money back by increasing resources to root out waste, fraud, and abuse, whether it's the IRS, whether it's in Housing, whether it's in health care fraud.

Mr. SCHIFF. Would the gentleman yield for 1 second on that?

Mr. GREEN. I see I don't have any time. I'll be glad to yield.

Mr. SCHIFF. I just want to emphasize your point, perhaps because I was a professional prosecutor for a number of years before I came here, I think every agency has to look to see how it can do things better. And I don't know of any reason why prosecutors or police forces are immune from that. I think everyone has that obligation. Still, investigation and prosecution is a relatively high, intensive manpower commitment. You need people to do investigations; you need people to do prosecutions.

There is a dichotomy. There are many in Congress, and, of course, many of our fellow citizens who say, "Let's have more convictions. Let's have more prosecutions." And then, "Let's cut the budgets of those agencies that are doing that." Well, they are dreaming. If you want more investigations and prosecutions, allowing for the fact that they have to look at how they can do things better, you had better fund the agencies or it's just not going to happen.

I yield back. I thank the gentleman.

Mr. SHAYS. Does the gentleman have a comment?

Mr. GREEN. One other question. On page 4 of your report, and, again, I like the report, and it goes with, I guess, the tenor of my concern that the rhetoric sometimes in Congress gets ahead of the real effort to solve the problem. I think some of our groups are engaged in that oftentimes. I think, on this issue, we don't need a lot of rhetoric; we need to deal with passing the legislation, as we talked about. I would hope that we could work together on it.

On page 4, where it says, "Despite this evidence of fraud and waste and failure to take adequate steps to eliminate the abuses, rhetoric and denial are postures of choice in Washington. Some Members of Congress, along with their outside supporters, claim there is no crisis. Others argue that the Federal Government—" again, you can say the level of crisis, but there's a crisis, I think, in Medicare fraud, and there's no doubt about that. And that needs to be dealt with.

Now, whether it's 2002, or we can deal with Medicare overall and say 2005, 2006, but fraud needs to be dealt with this year and not necessarily in the overall. Again, sometimes we get in the same position as you do, and sometimes our rhetoric gets ahead of the issues that we can probably do something about. I think we can, bipartisanly, deal with fraud, waste, and abuse, without necessarily getting into, you know, $270 billion, or whatever we want to talk about.

Thank you, Mr. Chairman.

Mr. SHAYS. Well, I thank the gentleman. I will just echo his comments that this clearly is something where it is, to use the words of someone, a no-brainer for all of us.

In one of the reports of the GAO, in the short summary, they say, "This final audit report points out that 26 percent of Florida home health agencies', HHAs, claims approved for payment by fiscal intermediaries in February 1993 did not meet Medicare reimbursement requirements." Would you be surprised to read that number of 26 percent, just slightly over a quarter, would any of you be surprised?

Mr. SCHATZ. No. I think that's one of the reasons why, when we say 10 percent, and certainly in some areas it's going to be more than 10 percent; in other areas it's going to be less, that that is certainly a conservative number.

Mr. SHAYS. One of the ways that the Republicans hope to slow the growth of Medicare is to get more savings out of waste, fraud and abuse.

My sense is, that that 10 percent number is very small. And it leads me, Mr. Mahon, to the whole concept of the all-payer. I just want a succinct statement again for why the all-payer is important

in terms of getting at fraud. If we just focus on Medicare or Medicaid, what is the liability?

Mr. MAHON. Several key points: 57 percent of the health care dollars spent in the United States every year are private sector dollars.

Mr. SHAYS. How much?

Mr. MAHON. Fifty-seven percent. That's 39 percent private insurance and 18 percent patient out-of-pocket payments.

Mr. SHAYS. Right.

Mr. MAHON. Government-program expenditures are 43 percent, of which Medicare and Medicaid are a portion. Then you have CHAMPUS and the other Federal employee plans. That's the first key point: looking at where the money is coming from.

Then the fundamental truths about how providers commit the crime. They defraud more than one payer simultaneously, to stay below the radar screen with each one as much as possible. They defraud public and private programs simultaneously, and not exclusively. If they do it to one, they do it to the other.

And everyone is looking for sufficient resources to combat the crime. Mr. Schiff, I think, just made one of the most compelling points: It is a labor-intensive investigation and prosecution process. If the objective is to put out of business a provider who is defrauding Medicare or Medicaid, does it really matter whether that provider is put out of business by the IG's investigation and prosecution or through a private payer's criminal prosecution or civil judgment that renders that provider ineligible to participate in Medicare?

The private payers have been investigating health care fraud for many years now, oftentimes very aggressively, and oftentimes they have confronted many roadblocks when it came to getting criminal action taken. They are very close to the crime. They understand how it's done. They've got the expertise and, in many cases, the manpower to go after it. They can be a very effective adjunct to government efforts, and they can work to the Government's advantage.

Mr. SHAYS. Thank you. That's very helpful.

Ms. Burgess or Mr. Schatz, do either of you have any other comments? I found this hearing very interesting. I am going to again emphasize that the more you can do to get us to deal with this issue on the Medicare bill this year, the better it will be for all of us. I really would try to emphasize again that that would be very helpful.

If there are no other comments from anyone, we will adjourn this hearing.

[Whereupon, at 12:25 p.m., the subcommittee adjourned.]

[Additional information submitted for the hearing record follows:]

U.S. DEPARTMENT OF LABOR

SECRETARY OF LABOR
WASHINGTON, D.C.

OCT 10 1995

The Honorable Christopher Shays
Chairman
Subcommittee on Human Resources
and Intergovernmental Relations
Committee on Government Reform and Oversight
House of Representatives
Washington, D.C. 20515

Dear Chairman Shays:

While we have not completed our examination of its impact on the Department of Labor's programs, we wish to express our views on H.R. 2326, the "Health Care Fraud and Abuse Prevention Act of 1995." We believe this legislation takes necessary steps to provide tougher defenses against fraudulent practices that drive up the cost of health care. We recognize that billions of dollars have been lost to health care fraud and abuse in the last few years.

We note that 18 U.S.C. 24(a)(4), as amended by section 201(a) of this bill, would define "Federal health care offense" to include "a violation of, or criminal conspiracy to violate section 501 or 511 of the Employee Retirement Income Security Act of 1974 (29 U.S.C 1131 or 29 U.S.C. 1141), if the violation or conspiracy relates to a health care benefit program." A "health care benefit program," in turn, is defined under 18 U.S.C. 1347, as added by section 202(a) of this bill, to mean "any public or private plan or contract under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract." Although the term "private plan" is not defined in this bill, we are concerned that the bill could be broadly read to include all health plans covered by the Employee Retirement Income Security Act (ERISA). If the bill is interpreted in this manner, its sanctions would apply to offenses committed against private sector employment-based health benefit plans.

There are approximately 4.5 million such ERISA health plans, providing coverage for about 120 million workers and their families with private employment-based health coverage. Given the significant impact H.R. 2326 as written would have on our ERISA responsibilities and the scale of the ERISA plan universe, we believe that this legislation should reflect the Secretary of Labor's important role in health care enforcement. We suggest revising the bill to make the Secretary of Labor also responsible, to the extent ERISA plans will now be covered for

health fraud enforcement.[1] For the same reasons, we also suggest that the Secretary be included in section 101(a), which relates to the investigation of health care fraud violations of federal law.

The Department's primary focus with respect to ERISA-covered health plans is to protect the benefits of participants and beneficiaries. In cases where private health plans participants and beneficiaries are the victims of fraud and abuse, criminal forfeitures and civil recoveries should be used to make participants and beneficiaries whole for losses before funds are paid into the Anti-Fraud Account.

Finally, we believe the provisions of H.R. 2326 amending the criminal law concerning health care fraud represent positive steps toward eliminating abusive practices that drive up the cost of health care. Under ERISA, the Secretary of Labor has responsibility for enforcing the provisions of Title I of ERISA and conducting investigations of civil and criminal violations relating to Title I and "other related violations of Title 18 of the United States Code" which include health care fraud. Therefore, we suggest adding language to clarify that the Secretary of Labor will have the authority to investigate the new Title 18 crimes as they apply to ERISA welfare benefit plans.

The Department would be pleased to work with your staff to develop language that would protect plan enrollees who are the victims of health care fraud. As the agency responsible for regulating employment-based health plans, we will continue to review H.R. 2326 for other issues affecting Department programs. We look forward to providing further input on this bill and to working with you on these issues.

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[1] The Department has civil and criminal oversight responsibility for all private sector employee health benefit plans under ERISA. The Pension and Welfare Benefits Administration (PWBA) conducts civil and criminal investigations of persons and entities that exercise discretion over ERISA plans and plan assets, such as multiple employer welfare arrangements (MEWAs). As you are aware, the Department administers and oversees many other worker-related health care programs, including the administration of the Federal Employees Compensation Act (FECA) program (medical benefits and disability compensation to injured Federal employees); the Black Lung Benefits program (medical benefits and disability compensation to former coal miners disabled from pneumoconiosis or "black lung"); and the Longshore and Harbor Workers Compensation Act program (benefits to certain injured and disabled maritime employees). The Inspector General investigates allegations of fraud in these programs and conducts certain criminal investigations of MEWAs and employee benefit plans as well.

The Office of Management and Budget advises that there is no objection to the submission of this report from the standpoint of the Administration's program.

Sincerely,

Robert B. Reich

U.S. Department of Labor

Inspector General
Washington, D.C. 20210

OCT 6 1995

The Honorable Christopher Shays
Chairman, Subcommittee on Human Resources
and Intergovernmental Affairs
Committee on Government Reform and Oversight
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Shays:

It is my understanding that you have left the official record open following your September 27, hearing on H.R. 2326, the Health Care Fraud and Abuse Prevention Act of 1995. I would like to take this opportunity to comment on the bill for inclusion in the record. Since its inception in 1978, the Office of Inspector General (OIG) at the Department of Labor has been heavily involved in combatting health care fraud. As you are aware, the Department of Labor administers, operates, or oversees many worker-related health care programs. The OIG has conducted many criminal investigations involving fraud in the Federal Employees' Compensation Act (FECA) program, which provides medical benefits and disability compensation to Federal employees who are injured; the Black Lung Benefits program, which provides medical costs and monthly compensation to former coal miners disabled from pneumoconiosis (black lung); and the Longshore and Harbor Workers' Act program, which provides benefits to certain injured and disabled maritime employees. The Department also has oversight responsibility for all employee health benefit plans that are covered under the Employee Retirement Income Security Act (ERISA).

I applaud your efforts in the bill's anti-fraud provisions. The establishment of an inter-agency coordinated approach to health care fraud promises to have a significant impact. In fact, in this era of diminishing fiscal budgets, it is imperative that the law enforcement community coordinate even more than it ever has before. Specifically, I would also like to thank you for recognizing the investigative role that the OIG at the Department of Labor has in this area. I look forward to working with Inspector General Brown, other Inspectors General, and the Department of Justice in the fight against health care fraud.

In addition to our statutory responsibility to monitor Departmental programs, the OIG has additional responsibilities carried out by the Division of Labor Racketeering which was created in an effort to combat the influence of organized crime in labor unions and employee benefit plans. Our initial entry into ERISA health care fraud involved investigations of multi-employer, union benefit plans. Those early investigations disclosed that organized crime elements had infiltrated benefit plans through the control of certain unions by organized crime families. These organized crime individuals siphoned millions of dollars out of legitimate union plans through excessive administrative costs, unauthorized participants, kickbacks from service providers, or outright embezzlement of plan assets. We have noted that the individuals engaged in these criminal activities are becoming more sophisticated and have branched off into new areas of criminal activity.

Because of our record of success with multi-employer union benefit plans, both the Congress and a number of State Insurance Commissioners urged us to expand our scope of investigations into certain non-union ERISA-covered benefit plans. This included varieties of fraudulent multi-state schemes associated with Multiple Employer Welfare Arrangements (MEWAs). What we have found in these investigations is that many of the same individuals who were engaged in criminal activities in the area of union plans, had moved into MEWA and other ERISA-related health insurance schemes.

I am of the opinion that H.R. 2326's amendments to the U.S. Criminal Code will greatly enhance the abilities of law enforcement agencies to combat health care fraud. In particular, I am pleased to see that health care fraud will be made a 10-year felony. I also support the new bribery and embezzlement statutes which now will apply to all aspects of health care fraud. The bill's broad definition of "health care benefit program" will include ERISA plans, and I believe that this will prevent fraudulent health insurance operators from avoiding prosecution by taking advantage of the confusion surrounding the preemption clause of ERISA. It is for this reason that I strongly support the inclusion of ERISA benefit plans under the definition of "health care benefit program" in H.R. 2326.

The ERISA bar found at Section 411 is a very effective deterrent against fraud. This bar prevents persons convicted of certain enumerated crimes from holding any welfare plan position (including employment as a paid "consultant"). This bar would be even more effective if Section 411 were amended to include the new health care crimes in H.R. 2326.

In line with these improvements, I might suggest one other area which could strengthen the battle against health care fraud. We have found the Racketeering Influenced and Corrupt Organizations (RICO) statute to be very effective in prosecuting health care fraud. The RICO statute bases prosecutions on certain enumerated crimes; that is, certain crimes are set forth in the RICO statute itself which can be used as predicates to a RICO prosecution. If violations of the new criminal provisions were added to RICO predicate crimes, the law enforcement community would have an even more effective investigative weapon in its arsenal.

Mr. Chairman, my staff and I are ready and willing to work with the Committee to combat health plan fraud. If you or your staff would like to be briefed on our efforts in the area of health care fraud, I may be contacted on (202) 219-7296.

Sincerely,

Charles C. Masten
Inspector General

U. S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

October 6, 1995

Honorable Christopher Shays
Chairman
Subcommittee on Human Resources
and Intergovernmental Relations
Committee on Government Reform
and Oversight
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This responds to your request at the hearing on September 28, 1995, for the Department's views on certain proposals relating to Medicare. For purposes of this request, we have reviewed H.R. 2389, the "Safeguarding Medicare Integrity Act of 1995." The Department of Justice has a very active health care fraud enforcement program which we believe would be undermined by certain of the bill's provisions. We understand that some or all of these proposals may be considered by the Congress in connection with its deliberations on H.R. 2425, the "Medicare Preservation Act."

Section 106: Consolidated Funding for Anti-Fraud and Abuse Activities Under Medicare Integrity Program. Although Section 106 is rather complex, it seems that this Section would create a Fund consisting of monies from the following sources: monies currently used by the Health Care Financing Administration to fund the anti-fraud activities of the Medicare carrier and intermediary Fraud and Abuse Units; proceeds of administrative penalty actions; criminal fines; and penalties and damages (after restitution and relators' awards) recovered under the False Claims Act. Pursuant to the bill, these funds would not be used to supplement the health care fraud enforcement activities of law enforcement agencies. Rather, the funds would be used to "enter into contracts with private citizens" for the review of activities of providers, audits of cost reports, education of providers, beneficiaries, and others.

The Department of Justice has several concerns about this Fund for private anti-fraud activities. First, by establishing an Anti-Fraud and Abuse Trust Fund to finance private contractors but not law enforcement and federal health care program agencies,

the bill arguably could be read to transfer to private contractors traditional law enforcement responsibilities, although we doubt this was the sponsor's intent.

Second, although the need for funding for federal health care fraud enforcement efforts has grown, the bill provides funding for private entities but no funding for law enforcement agencies. The number of health care fraud prosecutors and investigators simply has not kept pace with the dramatic increase in the number of criminal and civil health care fraud investigations and prosecutions presently handled by the Department of Justice. This problem will only grow more acute in the future. For example, the Federal Bureau of Investigation has 1760 health care fraud matters under investigation, up from 1051 in 1993. In addition, the Department of Justice receives health care fraud cases from numerous agencies other than the Federal Bureau of Investigation, such as the Department of Health and Human Services ("HHS") and the Department of Defense as well as private insurers. Further exacerbating the demand on resources, the bill itself imposes expanded duties upon the Department of Justice and HHS, such as the requirement that all requests for special fraud alerts be investigated and acted upon. The efficacy of any health care fraud enforcement program depends on adequate resources for law enforcement.

Our third concern involves the source of the funds for the new Anti-Fraud Fund. Specifically, the Department of Justice does not endorse depositing criminal fines into the Fund. Criminal fines are not presently deposited into the Treasury but rather into the Crime Victims Fund to be used to assist and compensate victims of crimes all over the country. We do not support diverting fines from this critical law enforcement activity.

Section 108: Establishment of Health Care Anti-Fraud Task Force. This Section requires the establishment of a Health Care Anti-Fraud Task Force, which would have a separate "accounting of its finances," and have a separate staff, distinct from the rest of the Department of Justice components. The Attorney General would be required to consult with an Advisory Group in connection with the establishment of the Task Force. We believe that it is unnecessary to separate the Department's health care fraud enforcement effort from the rest of the Department's enforcement activities in this manner. Such a structure represents an unnecessary administrative burden that could serve to detract from our overall enforcement efforts. By mandating fully staffed operational segments of the Task Force, the proposal limits the discretion of individual United States Attorneys to respond to changing investigative and prosecutorial needs, which may vary greatly over time and between judicial districts.

Moreover, the proposed structure risks disrupting the present health care fraud enforcement effort which has had so many demonstrated successes. The Attorney General in 1993 named

health care fraud enforcement her number two new initiative, behind violent crime. Since then, the Department has had a coordinated health care fraud enforcement program, headed by a Special Counsel for Health Care Fraud reporting directly to the Deputy Attorney General. The Special Counsel has been chairing an Executive Level Health Care Fraud Policy Group which has been meeting monthly since November, 1993 to coordinate the health care fraud efforts of the Department of Justice and HHS. As part of this effort, the Department of Justice has increased its investigations and prosecutions, facilitated greater cooperation among investigative and regulatory agencies and coordinated the use of all available sanctions -- criminal, civil and administrative.

At the local level, every United States Attorney's Office has a criminal and civil health care fraud coordinator. They lead health care fraud working groups in all judicial districts experiencing significant health care fraud. These groups allow all federal and state agencies working on health care fraud enforcement collectively to share information on emerging fraudulent schemes, develop joint enforcement strategies, and decide priorities. Changing this successful law enforcement structure to create a separate nationally based health care fraud task force would be counterproductive and risks omitting particular agencies with strong records of health care fraud enforcement.

Section 201 (c): Limiting Imposition of Anti-kickback Penalties to Actions with Significant Purpose to Induce Referrals. This Section would overturn case law interpreting the Medicare anti-kickback statute and serve to heighten the government's burden of proof in criminal anti-kickback prosecutions.

Kickbacks are pernicious because they corrupt the medical providers' decisionmaking, often replacing profit for patient welfare. Kickbacks have lead to grossly inappropriate medical care, including unnecessary hospitalization, surgery, drugs, tests and equipment, at great additional expense to the American consumer and taxpayer.

The courts have interpreted the Medicare anti-kickback statute (42 U.S.C. 1320a-7b) to prohibit the payment of remuneration if "one purpose" of the payment is to induce referrals of services which are paid for by Medicare. United States v. Greber, 760 F. 2d 68 (3rd Cir. 1085). See also United States v. Kats, 871 F.2d 105 (9th Cir., 1989); United States v. Bay State Ambulance, 874 F.2d 20 (1st Cir. 1989). In light of this interpretation of the criminal intent element of the offense, the government is charged with the burden of proving beyond a reasonable doubt that one purpose of a payment is to induce referrals. As with many intent based prosecutions, the

prosecution must often rely on circumstantial evidence to prove the intent required by the statute.

To further heighten the prosecution's burden of proof, as would occur upon enactment of Section 201(c), would seriously undercut the government's health care enforcement efforts in the anti-kickback arena. To require the government to prove that the remuneration was paid for the "significant purpose of inducing" referrals, is tantamount to immunizing a range of conduct which was, in truth, intended to induce referrals. Moreover, the phrase "significant purpose" is vague and will result in unnecessary and burdensome litigation. In sum, the proposed amendment will seriously undercut our anti-kickback enforcement efforts.

Instead, we believe Congress should be expanding our anti-kickback authority to cover the inducement of the referral of business that is paid for by any government health care program and to provide a civil anti-kickback remedy. Our anti-kickback enforcement efforts have confronted significant obstacles because of the limited coverage of the current Medicare/Medicaid anti-kickback statute. Defense counsel routinely argue that the statute does not apply unless the majority or totality of a provider's business is paid for by Medicare/Medicaid. They also contend that the absence of an explicit civil anti-kickback remedy limits the government's opportunities to recover damages and civil penalties. To rebut these arguments, kickback prosecutions now require extensive prosecutorial resources. Nevertheless, we were able to prosecute and settle two major anti-kickback cases in the last year obtaining convictions and settlements of $379 million in one case and $161 million in the second case, which returned significant savings to the Medicare Trust Fund and the Treasury. To limit our ability to bring such cases, rather than to strengthen our statutory authority, would seriously impair our health care fraud law enforcement efforts.

Section 202: Clarification of and Additions to Exceptions to Anti-kickback Penalties. This Section would immunize from prosecution the payment of remuneration with the intent to induce referrals, provided that the health care item or service involved is provided, inter alia, through an organization that assumes financial risk, or is a disease management program.

These statutory safe harbor provisions are very broad and may result in immunizing kickback activity which should be prohibited. Indeed, a large number of health care providers could arguably be construed as engaged in "disease management." We believe that additional safe harbors should be narrowly drawn and should be crafted only after a careful study of the practices which could be encompassed by the provision.

Section 204: Issuance of Advisory Opinions. This Section

requires the Secretary of HHS to issue advisory opinions concerning, inter alia, what constitutes a violation of the criminal Medicare anti-kickback statute. The Department of Justice opposes this provision on both legal and practical grounds.

First, the Department of Justice has the exclusive authority to enforce all federal criminal laws. This authority extends to all prosecutorial decisions, including those based on the Medicare anti-kickback statute. In that regard, the rendering by an agency other than the Department of Justice of opinions concerning the prosecutive merit or lack of prosecutive merit of a particular case would be beyond that agency's authority. Furthermore, we feel that it would be inappropriate for the Department of Justice to defer to another department's judgment, such as HHS, regarding what constitutes a prosecutable case under any criminal provision of the United States Code.

Second, we believe that the rendering of advisory opinions is generally ill-advised. This is especially true where, as in the instant case, a violation of the statute depends on proof of a knowing and willful intent to do the act proscribed. For obvious reasons, a putative defendant's presentation of the "relevant" facts is apt to be slanted and incomplete and, therefore would be a poor basis on which to render a prosecutive judgment. Assuming that HHS is not going to conduct an investigation of each advisory opinion request which is filed, the prosecutor will, in all likelihood, have inadequate information on which to base his or her decision.

Third, we are concerned that advisory opinions would produce unnecessary problems in the context of a subsequent criminal and/or civil prosecution by introducing additional factual issues into these cases relating to the interpretation and applicability of the advisory opinion at issue.

In sum, we believe that the rendering of advisory opinions would immunize the individuals who committed the conduct to which the opinion relates, and would engender complex litigation in other cases in which the defense would rely on advisory opinions.

Section 104: Voluntary Disclosure Program. This Section would mandate the establishment of a voluntary disclosure program. Since the Inspector General of HHS recently announced a pilot voluntary disclosure program, in conjunction with the Department of Justice, we question the need for this provision.

This Section provides that the Secretary of HHS may waive, reduce, or mitigate any sanctions against individuals who make voluntary disclosures, including statutory sanctions which include criminal remedies. As noted above, the Attorney General has the exclusive authority to enforce federal criminal laws.

Accordingly, the Department of Justice opposes this provision.

We also do not endorse the provision in Section 104 that would bar qui tam actions under the False Claims Act against entities or individuals who make disclosures with respect to acts or omissions which constitute grounds for imposition of enumerated sanctions. First, the False Claims Act already provides a reduction of liability of any person or entity where that person or entity has voluntarily disclosed wrongdoing to the government and satisfied other statutory criteria. Second, even if such a restriction were appropriate, the statute as drafted would presumably prohibit qui tam actions where the allegations of wrongdoing were not disclosed but somehow were related to the matters disclosed. That result is not warranted and unwise. Finally, modifications of the qui tam provisions, if any, should be done in the context of amendments to the False Claims Act generally and should not be limited to voluntary disclosures involving health care fraud.

Thank you for the opportunity to provide our views on these important proposals. Please do not hesitate to contact us if we may be of additional assistance in connection with this or any other matter. The Office of Management and Budget has advised that there is no objection from the standpoint of the Administration's program to the presentation of this report.

Sincerely,

Andrew Fois

Andrew Fois
Assistant Attorney General

cc: Honorable Edolphus Towns
Ranking Minority Member

ISBN 0-16-054984-1
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